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*ARCHIVES OF SURGERY.*



# ARCHIVES OF SURGERY.

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BY



JONATHAN HUTCHINSON, LL.D., F.R.S.,

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Royal College of Surgeons.*

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VOL. V.

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London :

J. & A. CHURCHILL,

11, NEW BURLINGTON STREET.

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1894

THE  
NEW  
MUSEUM  
OF  
NATURAL  
HISTORY  
OF  
LONDON

LONDON:

PRINTED BY WEST, NEWMAN, AND CO.

HATTON GARDEN, E.C.

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NOTE.—The reader is requested to observe that the Plates do not always bear consecutive numbers. They have been printed for a smaller Atlas of Clinical Illustrations of Disease, which will be published on completion of the Archives, and their numbers refer to their proposed position in that work.





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# ARCHIVES OF SURGERY.

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JULY, 1893.

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## MODES OF RECOVERY AS AN AID TO ESSENTIAL DIAGNOSIS.\*

IN the attempt to determine the essential nature of certain forms of constitutional disease, I cannot but think that we might make much use of the knowledge gained from results of special methods of treatment. Of the remedies which may be used in this way as a test of the real nature of certain skin diseases, arsenic stands in a foremost place. I think it may be said that we know for certain three things in respect to it : First, and by far the most important, it will in nine out of ten cases of typical pemphigus immediately stop the formation of bullæ, and, if persevered in, cure the disease. Next, it will in all cases of psoriasis, if pushed, cause the scales to fall, and very often bring about a cure. Thirdly, in cases in which herpes has been frequently recurrent, the continued use of arsenic will—with a few exceptions—definitely prevent such recurrences. From these facts we may fairly infer that any malady which arsenic can arrest definitely and speedily is probably in some alliance as to its real nature with one or other of those mentioned. It becomes, I think, very important in reference to all the different forms of skin disease which we may suspect of constitutional origin, to ascertain by careful observation what influence arsenic has

\* I use the term "Essential" as denoting an attempt to recognise the nature of a disease as apart from the more outside achievement of giving it a name.

on them. In the attempt to determine this influence, detailed narratives are the only trustworthy form in which the facts can be recorded. Statistics may be very fallacious, and so also, when we remember how very complex our prescriptions often are, may be statements that patients appear to have derived benefit whilst taking the drug. For the purpose to which I refer we want conclusive proof, if possible repeated several times in the same case, that arsenic did in the most explicit manner prevent the production of the morbid phenomena.

The boy who was the subject of portrait No. XXIV., in the New Sydenham Society's Atlas, afforded a good instance of what is meant. In him an eruption which was erythematous only, and which never showed any tendency to produce bullæ, always cleared away immediately when arsenic was given. The disease relapsed repeatedly, but never with its original severity, and it was always cured so definitely by arsenic, that at length the mother of the child became able to identify premonitory symptoms (fretfulness, &c.), and at once resorted to the specific. I have published this case in detail in the descriptive catalogue of the Atlas, my narrative extending over nine years, and recording finally a well-tested cure. During the last six years of this period there had been no recurrence.

In this case the disease was certainly not very closely allied with pemphigus, since it had occurred in repeated outbreaks, and had frequently disappeared completely, independently of the use of arsenic. Pemphigus diutinus is, as its name implies, a persisting disease. The effect of arsenic in entirely preventing the development of outbreaks, and in finally conquering the tendency to them, was, however, as definite as could be well imagined.

My inference from these facts would be that the disease in its essential nature probably stood between a herpes and a pemphigus. It was recurrent, and capable of spontaneous cure, like a herpes; but it persisted much longer than herpes usually does, and was attended by the grave disturbance of general health which we witness in pemphigus.

The disease which is now known as Dermatitis Herpeti-

formis, and concerning which we owe so much to the writings of Dr. Duhring,\* is one in which the effects of arsenic appear to be variable. In many of the cases recorded it is expressly stated that arsenic did not cure, whilst in others it was beneficial. It must, perhaps, be admitted that, in spite of all that has been written, it remains difficult to form a liminary definition of this disease. I would venture to suggest that in all cases which may be recorded in future, very careful attention should be given to ascertaining whether or not arsenic did exert any definite influence over the eruption. The drug should be used alone, and should, if necessary, be pushed. It might, not improbably, be found that the cases would divide themselves into two groups, one definitely amenable to arsenic, and the other not. We must carefully distinguish between those cases in which arsenic acts directly, as in pemphigus, and those in which a long administration is necessary. In pemphigus, as a rule, no fresh bullæ form after twenty-four hours' use of the drug; and in such cases it is difficult not to believe that the effect is produced through the nervous system: what we know as to the nature of herpes much favours such a supposition. It is quite possible, however, that in other cases, where prolonged administration is necessary, that the effect may be due to the actual introduction of arsenic into the tissues involved in disease. Such an hypothesis is perhaps the most probable as regards the influence of arsenic on a new growth. I am about to record two cases in which arsenic acted in the most specific and definite manner in the cure of dermatitis. In both its efficacy was tested over and over again, and was always the same. I am not sure but that some dermatologists would claim them both as examples of Duhring's malady. They presented, however, very marked differences from each other as regards the type of the eruption. The feature in which they agreed—and it is one which I think justifies me in placing them side by side—was that they were curable by the same drug.

The following are the notes of the first of the cases. The

\* Dr. Duhring's papers on this remarkable malady have been collected in a recent volume published by the New Sydenham Society.

patient was an attendant in a lunatic asylum, and was sent to me by a medical man who had the misfortune to be placed under his care. I will give the notes as I took them at the time.

*Pemphigus Herpetiformis of four years' duration—Immediate arrest by Arsenic—Relapses whenever the drug was suspended—Cure after two years' treatment.*

The following are the first notes of this remarkable case:—

A tall, well-developed man, aged 24, single, who had never had syphilis (Mr. W. H—).

His liability to the eruption began in the summer of 1886. He was then an attendant in an asylum. It commenced as "a bright red rash across the loins." Two months later it began to spread, and came out on his thighs, back, and genitals. From that time to this he has never had his skin quite clear. He has, of course, been under many doctors, and he has attended at special institutions.

He is worse in the winter months, and better in hot weather. He is now always chilly unless taking exercise. This liability is new to him. In boyhood he did not suffer from cold, and never had chilblains. He believes that arsenic always for a time arrests the eruption, but it never cures it quite.

The eruption has been all but universal. The only parts which have been exempt are the middle of the chest and the corresponding parts of the back.

Before he was liable to this eruption, he was very prone to sore throats, which are in his family; they used to keep him in bed a week at a time. Since his liability to the eruption he has had no sore throats. The eruption itself, however, sometimes extends to his mouth and throat. Every medical man who has seen the case has called the disease "pemphigus," and with that diagnosis he brings a letter of introduction to me from my friend Dr. G—, of E—.

The above description applies to Mr. H—'s state when I first saw him on February 23, 1890. It must be understood that the eruption had varied much at different times. When

I saw him he had nothing approaching to a bulla. On his neck and ears were numerous small vesications, but none were larger than peas. On his back and sides of abdomen the eruption consisted of groups of spots which were, apparently, dried-up vesicles, and which, arranged in a somewhat corymbiform pattern, looked much like receding herpes zoster. They were symmetrical, and occupied almost the entire surface. On his limbs the eruption was much of the same character, but less corymbiform; on the legs more inclined to form scabs, and on the forearms presenting the condition of erythematous areas only. There were but few spots on his face, and ill-marked in character. His scalp hair was thin. He said that it had been "brought off by the eruption," and that he had often had crops of vesicles over the whole head. His genitals were free, but had, he said, often suffered. The front of his chest and the outer scapular regions of back were quite free, and showed neither pigmentation nor scars. On other parts the skin was in many regions deeply browned, and covered with little scars which the eruption had left.

I thought at first sight that his palms were free, but he showed that there were some deeply-placed spots which were threatening to vesicate. These were more plentiful on the joints of the fingers than in the palms. His own explanation was the skin was too thick for the fluid to get to the surface, and he said that the blisters would dry up and then cause the skin to peel. They made his hands feel stiff and sore. He had often had both palms and soles affected. The nails had always remained quite free, and were hard and brightly polished.

I inquired whether he had ever had large bullæ anywhere. The largest had, he thought, been on his ears, and were as big as shillings. It did not seem that on other parts they had ever been bigger than peas, and in many instances he described pustules rather than vesications on his thighs and abdomen. Throughout he had maintained good health, and had taken food well. He was accustomed to beer three times a day. His bowels were usually rather costive. His eruption had made him, he said, weary of his life, for he

was never well, and the irritation often prevented him from sleeping, and tormented him during the day.

As regards the occurrence of the eruption in his mouth, he asserted that it often came there ; but there was nothing to be seen when he was with me.

The prescription which I ordered contained four minims of each of Pearson's and Fowler's solutions of arsenic. This was commenced on February 23, 1890, and on March 4th the patient reported that he had never been so well during the past four years. There was not a single vesicle left, and the skin was quite clear, excepting for numerous small pigmented scars. He stated that the spots began to disappear on the day following the commencement of the medicine. We had used no local application whatever.

On June 2nd my notes state that the eruption was threatening to appear again, in spite of the continuance of the arsenic. During the four months which had intervened, he had been almost wholly free, but had always found that if he left off his medicine for a week some fresh spots would come out. "His present relapse, although decided, is but slight. He has, however, some groups of spots arranged almost like herpes on the borders of his armpits, in the bends of his elbows, in the groins, and along the iliac crests. They are arranged quite symmetrically. There is one little spot just above the inner canthus of each eye. He complains that his skin generally feels hot. He says that he always knows where a vesicle is coming, a day or two before it appears, by a burning sensation (this is exactly what occurs in herpes). The vesicles are exceedingly small, and can hardly count as bullæ. They are coming out exactly where the white scars left by former eruptions are most abundant. There is some congestion of the skin in streaks about the groups of spots (again just like herpes). He says that he has not felt so well for ten years past as during the four months during which he has been free from the eruption and has been taking arsenic. I find that he has been drinking beer more freely, and I have my doubts as to whether he has continued his medicine regularly."



Advised to leave off beer entirely, and to take his medicine more punctually.

My next note is on August 21st, and records that for nearly three months he had been free from eruption. There had been no vesications whatever, but a few little hard spots would still occur occasionally on his arms, between his fingers, and on the sides of his heels. These did not vesicate nor itch, but would persist for a week or more, and then disappear. I had increased the dose of the arsenic, and added a little opium and two grains of quinine. Excepting occasional diarrhœa, there was no evidence of disagreement of the arsenic, although he was now taking ten minims four times a day.

On October 2nd my notes state that, the medicine having been left off for three days on account of diarrhœa, a few fresh blisters had appeared on the face; they had, however, soon vanished on his resuming the medicine. He had now for some months been quite free on the body, but was still liable to little red spots on the feet, from which the skin would peel. It seemed possible that these were due to the arsenic, as he had not been liable to them previously. He was now taking twelve minims (six of each of the preparations) four times a day; with two grains of quinine. He was gaining flesh.

On October 30th he was still quite free from eruption, but suffering much inconvenience from excessive perspiration of his feet. They perspired so much that his socks were soaked, and the skin became sodden like a washerwoman's hands. The softened epidermis was in places lifted by fluid under it. His hands were not affected. There was no tingling or numbness about his feet.

As I attributed the condition of his feet, described in the last note, to the arsenic, I advised him to leave it off entirely for a time, and substituted tincture of belladonna in ten-minim doses; the quinine pill was continued.

On November 4th (that is exactly one week after leaving off his arsenic) Mr. H—— returned to me with a very decided tendency to a relapse of his eruption. Thus we had a demonstration that it had been the arsenic, and not the

quinine, which had kept it in abeyance. On his face, arms, and body there had appeared a great number of very small vesicles, which were very irritable. The perspiration of his feet was much less. I felt obliged to advise him to again take the arsenic.

My note on December 4th states that since we began the arsenic again the spots have ceased to appear. His soles have, however, again begun to be irritable and to perspire profusely; they are erythematous just on the parts pressed upon in standing, and the epidermis becomes sodden, and can be rubbed off every morning. He says that "he could wring his socks several times a day from the perspiration." It is a hot perspiration, and his feet "steam." He is engaged in an occupation which involves much standing. His right foot easily goes to sleep.

After the last date we never again gave the arsenic in such large doses; but we were obliged to continue it, in order to keep him clear of the eruption, and to combine with it considerable doses of opium, in order to prevent diarrhœa. It may possibly have been from the opium that we observed some failure in his general health.

On February 1, 1891, I wrote:—"He looks wan and pale, and thinks that he has been losing flesh for three months. His medicine had not appeared to disagree in any definite manner until a week ago, when it caused griping and diarrhœa. The symptoms used to come on five minutes after the dose. His eyes became very yellow. He left off the medicine three days ago, and the diarrhœa, &c., at once ceased. He has become very swarthy, parts of his trunk, especially over his hips, are almost black. The colour is diffused. Although he has left off the medicine only a few days, he is already threatened with some return of the old eruption. On the trunk there are little red papules under the skin, but on the face there are a few very small vesicles. His feet still perspire very much, and are somewhat congested, but they are not nearly so red as they were formerly. The belladonna appears to have much diminished both the perspiration and the congestion."

At the date of this last note, I made a demonstration of

the patient before a post-graduate class as an example of the discoloration of the skin which we sometimes observe from arsenic, and also to show the condition of the soles of the feet. This was on February 4th, and I then advised him to leave off the arsenic, as I feared it was injuring his health. Within three days of doing so, however, some fresh spots appeared, and of his own accord he resumed the use of the drug in half-doses. When he came to me again on February 27th, the eruption appeared to be kept in check, but not quite completely so. He had on various parts little erythematous papules which showed some tendency to vesicate, and there were a few small definite bullæ on his face; his feet were hot and perspiring, and the palms of his hands showed little corn-like indurations.

It is not necessary to continue the detailed notes of this remarkable case any further. Enough has been recorded to prove, beyond any doubt, that arsenic, and arsenic alone, possessed the power of controlling the eruption. The patient is still under my occasional observation. He is in good health, and has recently married. I have allowed him during the last year to take his arsenic mixture at his own discretion, insisting, however, that he should only take just enough to keep his skin free. Much smaller doses suffice for that purpose now than formerly, and he is often able to leave it off for a few weeks together. The discoloration of his skin has to a large extent disappeared, and he is quite free from the intolerable itching and burning sensations which used to torment him. We may record, therefore, that the treatment has in the end conquered the malady.

A few words may be permitted as to the real nature of the disease. I might sum up my own impressions by calling it herpetiform pemphigus. It was a symmetrical eruption, but its development and the grouping of the spots were like herpes. Some of the vesicles, however, were globular, just like those of pemphigus, and they showed none of the tendency to spontaneous disappearance which characterises herpes. They yielded to arsenic just as promptly as pemphigus does, and recurred as speedily when it was left off. The effects of that remedy afford us, I think, very valuable evidence as to the essential nature of the disease.

## 10 MODES OF RECOVERY AS AN AID TO ESSENTIAL DIAGNOSIS.

*A case of Herpetiform Pemphigus which relapsed frequently during many years, and was always controlled by Arsenic.*

The second case to which I have referred, is that of a patient named Esther Ann B——. This woman was aged 42 in 1875, at which date I had her portrait taken, and exhibited it in the annual Museum of the Medical Association at Edinburgh. I then named it “A pruriginous herpetic, or vesicating eruption, leaving scars, frequently relapsing, and often cured definitely by arsenic.” Mrs. B——’s history then extended back several years, and was as follows:—Before the eruption first appeared, she felt weak and languid; during her pregnancies she had often suffered from pruritus vulvæ. The eruption began in 1870, just after her last confinement; the parts first affected were, as far as she could remember, the head and neck. During 1871 and 1872 she had much distress from the eruption, which, although better at times, never left her altogether. It displayed however, distinctly a tendency to die away, as she called it, and would then again relapse. In 1872, at Christmas, she had a very bad attack, and for the first time came under my observation at the Hospital for Diseases of the Skin. She was at this time a widow, having lost her husband about a year after the beginning of the eruption. We did not at first give arsenic, but on October 3, 1873, this remedy was prescribed in three-minim doses of Fowler’s solution. On the 17th of that month she was much better, and on the 31st she was quite well. In December she had a relapse, having left off her medicine, and in January again she was quite well. It would be tedious to recapitulate in detail the account of the relapses and their treatment. At the time that I first saw her, she had for about four years never been quite free, and never nearly so for more than a few weeks at a time. After the treatment by arsenic was commenced, she remained under my observation more than four years, but I often did not see her more than once or twice in a year. A few weeks of the arsenical treatment always sufficed to clear her skin, and on several occasions, whilst continuing it more or less regularly, she had an entire year without a relapse. A severe relapse, con-

sequent upon her having left off her medicine for some time, occurred at Christmas, 1875; and it is her state when she presented herself at the Hospital at that date, that is depicted in the excellent portrait by Burgess which I have mentioned. It may be well, therefore, in connection with that date and the portrait, to describe the characters of the eruption.

It may be said, in brief, to have partaken of the features of herpes and of pemphigus. The vesicles and little bullæ were arranged in streaks and groups, exactly like those of herpes; and although some of the bullæ were large enough to have been called pemphigus, none of them were quite round. The vesicles occurred in great abundance on the back and shoulders, also on the chest, upper arms, extensor surfaces of forearms, on the hands, and on the forehead, cheeks and neck. Formerly they had been present on the scalp, amongst the hair, and on the thighs and legs. Some of the vesicles were distinctly compound, like those of herpes; and others formed little blebs, the size of horse-beans. Before they appeared there was always much burning and itching, and when they dried up, they left the skin intensely pruriginous. Amongst the parts which were definitely avoided were the loins, the genitals, and the upper parts of the thighs. Mrs. B—— looked older than her years, and was somewhat pale and haggard, but it must be borne in mind that in addition to this trouble, she had had a good deal of domestic sorrow. She had borne several children (all before the commencement of her skin disease), and five of these were living. None of her children had displayed any irritability of skin, and she herself had never had anything which she called nettle-rash.

My notes on December 10, 1875, when Mrs. B—— attended with a relapse, state that she had then been free for the greater part of a year. She was, as usual, quickly cured by the arsenic mixture. My note on April 18, 1877, states that she had left off the medicine for six months, and that she had been entirely free from eruption for about a year. The spots had been returning for about a fortnight, and many of them were already beginning to dry up. On this occasion, although her spots had for the most part disappeared in the

course of a few weeks, she remained under treatment till June. After this last date (June, 1877) I have no further notes of her case, but I believe that she continued to attend, as formerly, once or twice in the year, for several years longer; and that the arsenic continued to display the same specific power as before, in keeping her skin clear, so long as she continued to take it.

If we venture to assert that in this case the specific power of arsenic was just as definitely proved as it usually is in pemphigus, we must admit that the tendency to severe relapses was considerably greater, or perhaps it ought to be said that the relapses, when they did occur, were more severe. The state of the eruption as depicted in the portrait (which shows the shoulders covered with eruption) sufficiently proves this assertion. When common pemphigus has been cured by arsenic, the relapses are, I believe, not usually severe; but in this instance they were as bad as the original attack. Had the poor woman been able to give herself more attention, and had she been willing to continue her attendance at the hospital and to go on with her medicine when quite well, I think it not improbable that all relapses would have been avoided. It will be seen that on several occasions she remained quite free, in spite of having left off the medicine, for several months at a time.

The appropriate name for such a disease as this is, I think, "Herpes-pemphigus." I have no doubt that this latter name fairly expresses its relationships, and that, as to cause, it partook of the nature both of herpes and of pemphigus. In some of its features it resembled both, and the drug which cures the one and prevents the other exhibited in a most unquestionable manner its efficiency for both purposes. The case differs in some features, although not, I think, essentially, from the one which has preceded it.\*

\* In connection with these cases, I may again ask the reader's attention to the fact that the New Sydenham Society has just reprinted a collection of the important papers which Dr. Duhring, of Philadelphia has from time to time published on the disease which he names Dermatitis Herpetiformis. I have little doubt that Dr. Duhring will claim my cases as examples of his malady. I have preferred, however, in the attempt to ascertain their essential nature, to let them stand unnamed. Dr. Duhring's papers should be read carefully by all interested in the subject.

*(To be continued.)*

## ON PORRIGO AS AN EXAMPLE OF SURFACE-CONTAGION.

*(Part of a Post-Graduate Lecture delivered Jan. 31, 1893.)*

I PURPOSE, to-day, to ask your attention to a large natural group of skin diseases, which begin and spread entirely by what we may call surface-contagion. We will put aside for the present all those eruptions which are due to surface-irritation, such as scabies, eruptions from pediculi, heat eruptions, and the like. We will take only those in which the clinical evidence, in some cases strengthened by the employment of the microscope and in others not, makes it almost certain that there exists a contagious materies, which is transferred from part to part on the exterior of the body, and to which all that we observe is due. The first group of skin diseases due to surface-contagion is that of the maladies which have been proved to be of cryptogamic origin. To this group we apply the name *TINEA*. We count in it *tinea favosa*, or common favus; *tinea tonsurans*, or common ringworm; and *tinea versicolor*, the well-known liver-spots. All these begin by the implantation of a fungus on the skin, and all have a parent patch from which we assume, almost with certainty, that the rest are developed. In all, microscopic confirmation of the diagnosis is usually very easily obtained. They are contagious, and contagious only; and although the liability to them is much influenced by the age of the patient, and possibly somewhat by the special anatomical characters of his skin and hair, in none of them does the state of the general health exercise any great influence. I leave these diseases aside for the present, and with them a few others which are, either certainly or probably, allied to them, such as the varieties of ringworm which occur in hot climates, the

so-called *eczema marginatum*, and *alopecia areata*. Before, however, quite leaving them, it may be desirable to remark, in order to obtain as much light as we can upon other branches of this subject, that whilst both *favus* and ringworm are most common in childhood, *tinea versicolor* is never seen until a near approach to adult age, and that, with the exception that common ringworm usually appears to wear itself out as adult age is approached, yet that with this partial exception, all of them are capable of quite indefinite duration. Lastly, let me add that none of them are, with the rarest exceptions ever seen in old age.

Our forefathers used very freely the word "porrigo," and applied it with various adjectives not only to the diseases which we now place in the *tinea* group, but also to various forms of *eczema*, as well as to the special malady which I am now about to describe. On account of the vagueness of its meaning, the name in question has of late years fallen almost into disuse. I venture to ask that we should rehabilitate it, but in doing so, let me be understood to desire that it should receive a strict and liminary definition. I would apply the term *porrigo*—and this is no new use of the word, for it is what I was taught in my student days—to an eruption which is sometimes classed, but very erroneously, as *eczema*, but which is contagious, and contagious only, and which is very easily curable by certain local applications. I infer its nature partly from the means by which it is cured, and may at once say on this head that the most efficient remedy is the application of an ointment containing some preparation of mercury, the ammonio-chloride, or the nitric-oxide. The simplest examples of what I mean by the term *porrigo* occur in cases which are tolerably common in family practice, in which a child of delicate skin has had a scratch which has festered. From the secretion thus produced other sores may be developed, either near to it or on distant parts of the body. If there be other young children in the family, they very probably will catch the disease by contagion, and the mother or nurse who attends to them may very likely get sores on her fingers. Both in the children and in the nurse there is a remarkable proneness for the suppuration to affect the roots of the nails. The next



example of the disease which I will mention is that which occurs on the heads of neglected children who are troubled with lice. In a large majority of cases pediculi are not attended by any inflammation of the skin which they irritate: at any rate, there is no fluid effusion on its surface. Not unfrequently, however, in children in whom the skin is, perhaps, especially irritable, or in whom the scratching has been exceptionally violent, festers form, and the whole scalp becomes involved in inflammation, attended by much fluid effusion, and the formation of thick crusts. Now the character of these crusts on the scalp is exactly the same as those seen occasionally when porrigo, beginning from a scratch, has spread to the hairy scalp. In both cases the scab is thick, heaped up, resembling dried honey in appearance, and having a more or less offensive smell. In both cases it is very likely that the lymphatic glands in the neck will become enlarged, and at the same time very unlikely that they will suppurate.

A third group of porrigo cases, much less common than the other two, but in which yet more virulent properties of contagion are often displayed, is that in which the disease begins from vaccination. The annals of vaccination, and especially those of the anti-vaccinators, contain many accounts of epidemics of impetigo which appeared to originate from vaccination sores. In all cases it is the vaccinated child itself which first suffers, but from it the disease may spread to brothers and sisters, parents and nurses. The features of the eruption in all these cases is similar. The initial lesion is not a pustule, but a little vesication or bleb, the covering of which is very delicate and soon gives way. On the abrasion thus formed a heaped-up crust is produced. The skin does not become diffusedly inflamed, and on the parts intervening between the crusts it does not even show any redness. The contagious forms of porrigo originating from vaccination are curable by a white precipitate ointment, just as easily as are the other forms. In the vaccinated child it is always the parts near to the vaccination sores themselves which are first infected, and we are therefore, I think, entitled to assume that it is a local inflammation, consequent on injury to the skin, and that it has nothing to do with vaccinia as a specific febrile

malady. I have recently had an opportunity for studying a workhouse epidemic of this form of porrigo, and you will find the facts described at some length in the third volume of my ARCHIVES. It occurred in the maternity department of the St. Pancras Workhouse. It began on a vaccinated infant, but it subsequently attacked all the infants born in the establishment, although vaccination was desisted from. The eruption, on account of its being attended by bullæ, was at first called "pemphigus," as indeed other epidemics of a similar kind have been named, but it had nothing whatever in common with true pemphigus, which is a persisting and constitutional disease, curable only by arsenic, whereas this very quickly got well under a simple local treatment. In many of the infants affected in the workhouse the spots occurred on the hands as well as on other parts, and not unfrequently the finger-nails suffered. The eruption was not as a rule developed with symmetry, but occurred with much greater severity on some parts than on others. In several cases the mother of the affected infant contracted the disease, and in these instances the eruption always appeared on the skin of the mamma or adjacent parts where the infant's head had rested. Thus I feel sure you will admit that I am entitled to assume that this malady was a local one, and not due to any infection in the system generally. You will find in my ARCHIVES the description also of another epidemic, not occurring in a workhouse, but which spread from house to house amongst new-born infants and others who were attended by a nursing sisterhood. The facts of these two epidemics alike made it certain that the materies of contagion was a very subtle one, and not to be destroyed by any ordinary precautions of cleanliness. In the case of the workhouse this conclusion was very strongly enforced by the fact that although the wards were disused for six weeks, whitewashed, &c., and the nurses given a holiday, yet the disease reappeared as soon as the wards were reopened. I have little doubt that in both epidemics the contagion was spread by the hands of the nurses, or perhaps by their dress, and this in spite of the most sedulous washing and the employment of antiseptics.

There can be no sort of difficulty in distinguishing porrigo,

such as I have here described it, from eczema; and, as a matter of fact, the diagnosis has been well understood for the last half-century. As a student I was myself taught that porrigo could be cured in a week or two, whilst eczema might take many months, and the difference between the thin crusts with diffuse congestion in the one, and the heaped-up crusts without any general redness in the other, was carefully pointed out. If, however, other means of diagnosis were wanting, the case is one in which the difference in success of measures of treatment is abundantly sufficient.

In the year 1862, a gentleman to whom dermatology is much indebted, the late Dr. Tilbury Fox, described a malady which he named "*impetigo contagiosa*," and his account of it was subsequently accepted by various other authorities. Dr. Fox admitted, however, that it was the same malady which had been called porrigo by others; and most of his statements coincide very exactly with what I have just said about it, and it is certain I derived my knowledge of it long before he wrote. He, however, adds certain features to his *impetigo contagiosa* which are quite foreign to my porrigo. He asserts that it is a febrile malady, preceded occasionally by smart fever, and adds, "There is clearly an affection of the system at large before the occurrence of any eruption." He asserts also that the natural course of the disease is a short and definite one. Now these statements are not applicable to porrigo as I understand it. I do not believe that the slightest febrile disturbance precedes the eruption, but that the latter always begins locally, from the inoculation of a contagious secretion. Nor, although the disease is usually of short duration, do I believe that it runs a definite course, or that it has any tendency to spontaneous cessation. I would call it rather a disease that is easily curable; and on this point, as well as on many others, in spite of what I have just quoted, Dr. Fox's experience seems to have been the same as my own. He, too, believed that "the secretion is an active agent, by means of inoculation, self-practised by the patient in scratching, in transmitting the disease from one part to another." He, too, wrote, "I invariably use an ointment containing five grains of the ammonio-chloride of mercury; this rapidly cures the

disease." I cannot, therefore, doubt that most of the cases which supplied Dr. Tilbury Fox with materials for his conception of *impetigo contagiosa* were examples of what had long been called *porrigo*, and for which I should still prefer to retain that name. It remains, however, a question, which I by no means wish to put aside hastily, whether there are any cases which are really constitutional in origin, preceded by fever, and which show a tendency to run a definite course, and to recover spontaneously, independently of treatment. It is, however, I think, not too much to ask that any one who in the future asserts that there are such cases, should record the facts carefully, giving the temperatures during the stage of incubation, and that in order that we may believe the disease runs its course naturally and comes to an end spontaneously, he should abstain from interfering with it by the means of so efficient a remedy as the ammonio-chloride of mercury.

## ON CERTAIN DISEASES OF THE TONGUE.

(Continued from Vol. IV., p. 322.)

*The Filmy Tongue* (see Vol. IV., p. 318).

One of the best marked examples of the *filmy tongue* which I have seen occurred in the case of a man named K——, who was brought to me by Dr. Matheson, of Soho Square. He was forty-five years of age, a heavy smoker, quite free from skin disease, and, excepting a little dyspepsia, in good health. The patches on his tongue, which had given him great trouble, had been first noticed about fourteen months before I saw him. He thought that a little blister caused by smoking was the first thing that he noticed, but about this there might be some doubt. Nothing whatever of the nature of an excoriation had occurred since. The patches were, as usual, symmetrical, and, again as usual, of larger size on one side than on the other. They extended lengthwise, as two broad streaks, one on each side, near to, but not touching, the edge. In front of these principal streaks there was a number of small spots which advanced up to the tip of the tongue. Inside the buccal pouches was a number of pearly white streaks which branched. These were chiefly far back in the cheek, and not, like the smoker's patch, near to the commissure. Many of his teeth were capped with gold, but none of them stopped with amalgam. The patches were, as usual, rather ill-defined at their edges, and they were distinctly perceptible to the finger as being slightly rougher and harder than the rest of the tongue. When looked at with the lens they were seen to be composed of slightly-raised, rounded, filiform papillæ, which were glued together by a filmy, white material.

We advised Mr. K—— that he should at once leave off

smoking, and prescribed a mixture containing arsenic, with a solution of chromic acid for local application.

I did not see Mr. K—— for a second time until April 13, 1893, about eight months after his first visit. He then called on me again with Dr. Matheson. He reported that he had never smoked since our last consultation, and said that, within a month of it, as he thought as a result of the medicine, the patches had almost disappeared. He was so nearly well that the medicine was left off. During the last month or two the tongue had relapsed, and, in spite of again taking the medicine, there had been no improvement. The patches were much as at the time of the former consultation, but not so conspicuous; more especially those in the cheek had much diminished. No skin disease whatever had developed. Although there was not the slightest reason to suspect syphilis, I now suggested that, as the arsenic had failed, he should try the bichloride of mercury.

Another example of the filmy tongue, exactly like the rest, was shown me by Dr. Abraham at the Hospital for Skin Diseases. The patient was a shopman of about twenty-six years of age, who had never had syphilis, and in whom we could detect no skin disease. Asked if the patches gave him any trouble, he said none whatever, excepting that it was very inconvenient coming to the hospital. This was in February, 1893.

Another very good example of filmy patches on the tongue occurred in the person of Mrs. D——, who was sent to me by Dr. Jeaffreson, of Wandsworth. This lady was very stout, and had suffered from threatenings of gout in various forms. Her age was fifty-two. She had had intertrigo-eczema under the breasts, but this had been cured, and she had no other skin disease. The state of her tongue was most

On the greater part of its surface the papillæ were  
 sides on its anterior half there were sym-  
 ch were quite smooth and slightly glazed.  
 sed below the level of the surrounding  
 bluish tinge. On careful inspection  
 apillæ on these patches were by no  
 oothed over and, as it were, glued

together by what looked like a thin layer of bluish size. The patches were not abruptly rounded, and were in some parts accurately defined, and in others not so. One, as a sort of streak, occupied the median fissure of the tongue. There were similar white patches, but longer and more streak-like, in the cheek pouches about the line where the teeth would meet.

In this case no special cause could be assigned for the patches on the tongue, and they caused scarcely any inconvenience. As usual, there was but little sense of soreness. It was conjectured that they might have been caused by drinking effervescent waters too freely, but about this there was nothing very definite to be said. I saw Mrs. D—— first on April 26, 1893, two or three months after the patches had first been noticed. She came to me again on May 20th, when I found the conditions exactly as before.

*Pneumonia after Écraseur-Excision of the Tongue for Cancer—Details of after-treatment.*

In an address which I gave at Liverpool, about a year ago, I took credit, I hope not boastfully—and not to myself, but to my mode of operating—for the fact that I had never in private practice lost a single patient after excision of the tongue. My operations of late years have all been by means of the écraseur with a cold wire, thus entirely avoiding all risk of hæmorrhage and subsequent danger from the passage of blood into the trachea. The critics of this operation are fond of suggesting that the wound left by the écraseur is apt to be for a time in an unhealthy condition, such as may easily permit of septic infection of the lungs. To this my reply has always been that, although I have done many such operations, I have never, in a single instance, encountered pneumonia afterwards. I am speaking as to the results of private practice, for at the London Hospital I did once lose a patient from pneumonia after excision of the tongue. Nor am I any longer in the position to renew my boast as to operations in private, for I have just had to deal with a very critical case. The facts of this case are briefly as follows:—

More than eight years ago I performed, in the case of Major O'D——, then aged 45, a very free surface operation on account of sclerosis with a papillary condition on the dorsum of his tongue. It was a matter of debate whether the condition was actually epithelial cancer or not. I cut away the tip and surface very freely with scissors. The parts healed well, and he continued his vocation as a police magistrate in Ireland for eight years. At the end of this time he returned to me with an extensive ulceration on the surface of what remained of his tongue, which was unquestionably cancerous. The condition had been developed during the last six months. He was admitted into a surgical home, and I removed the whole of his tongue by means of the wire *écraseur*. It was all but a bloodless operation, and certainly no blood passed into his trachea. The progress was very satisfactory during the first four days. On the fifth he seemed languid, and on the sixth I allowed him to take an hour's drive in the open air, during very warm weather. After his drive he had a rigor, and on the next day there was double pneumonia. During the ten days following he was in a critical condition, his temperatures being variable and sometimes high. I had the assistance of Sir Andrew Clark and Dr. Douglas Powell in the treatment at this stage, and eventually complete recovery ensued. It was a question whether the pneumonia and complicating pleurisy were more probably due to septic infection from the mouth or to exposure on the occasion of his drive. The condition of the wound in the mouth had been satisfactory throughout, and, as the patient had eighteen months previously suffered from a severe attack of pneumonia during influenza, it is perhaps fair to assume that the operation on the tongue had really nothing to do with it on the present occasion. I am, however, bound to record the case, having so recently and so strongly asserted that *écraseur* operations are not followed by lung complication. In reference to this point I have to ask attention to a little matter of detail. My after-treatment of these operations has always been by a mouth-wash of spirits of wine. This the patient is made to use very freely indeed, constantly rinsing his mouth and



spitting out the fluid. In the present instance, for the first time in my practice, a spray was used, by a too zealous nurse, who had employed it in other cases. It occurs to me as quite possible that a spray is the very best means of facilitating the inhalation of septic particles, and that very probably a mouth-wash is far safer. I shall most certainly in all future cases forbid the use of the spray, and keep strictly to an old, well-tried friend. The mouth-wash which I use is made by putting two tablespoonfuls of spirits of wine into a tumblerful of water. If the wound is unhealthy, I frequently have it swabbed with a much stronger solution.

## EPIDEMICS OF ECZEMA-ERYSIPELAS.

GREAT attention was attracted about two years ago to the occurrence of epidemics of a contagious form of eczema in two of our large London workhouse infirmaries. Dr. Savill, of the Paddington Infirmary, who was the first to perceive the peculiarity and importance of the cases, subsequently published the results of his experience in a detailed and well illustrated essay. I have myself repeatedly alluded to these cases in my ARCHIVES, and have given some particulars of an epidemic of a similar kind, which had previously occurred in a lunatic asylum\* in Scotland. My conjecture as to the real nature of this form of dermatitis is that it is a sort of hybrid between eczema and erysipelas, and that not improbably it is the presence of a micro-parasite, allied to that of erysipelas, which renders an eczematous process contagious from patient to patient. Through the kindness of Dr. Knox, of the Bethnal Green Sick Asylum, I have just been made acquainted with the facts as regards another epidemic of this remarkable disease, which has occurred during the present summer in the establishment under his charge. I have visited the Asylum twice and seen Dr. Knox's patients. No fewer than eighty-four cases have occurred, some of them only slight, but many severe, and there have been four deaths. For the most part middle-aged or elderly people have been sufferers, and all the deaths have occurred in those already enfeebled by age or disease. As to the character of the malady in this instance, I may briefly say that all the features present in the epidemics at Paddington and Marylebone have been repeated here. The cases have been for the most part indistinguishable from the isolated examples of

\* The Greenock Parochial Asylum. An account of this epidemic has since been published by Dr. Elkins.

general eczema, which we frequently witness in aged persons. A case upon which I lectured in the Cleveland Street Hospital, and which was published three months ago in the *Clinical Journal*, may serve as a good example of the more severe type. In that instance the patient's hands and feet peeled in glove-like layers of epidermis exactly as Dr. Savill described it in his cases, and as I have recently witnessed it in Dr. Knox's patients. This extensive and very definite peeling has been relied upon as one of the distinguishing features of the cases which occur in epidemics. It is, however, I am sure, one that is common to all forms of acute dermatitis in the least approaching the type of erysipelas. Dr. Knox tells me that, in several of his cases in the acute stage, any one observing the patient's face, the swollen eyelids and distorted features, would have at once diagnosed erysipelas; and in this stage the temperatures were all somewhat high. After the most careful inquiries as to any probable cause, whether local or dietetic, Dr. Knox had been obliged, as were his predecessors in this matter, Dr. Savill, Mr. Lunn, and Dr. Elkins, to confess that he was baffled. There is not the slightest reason for believing that these epidemics are due to any special kind of soap, or to any particular form of food. They may begin apparently spontaneously, and the mode of transmission is by contagion only. The epidemic at Bethnal Green is now ceasing, and Dr. Knox tells me that he feels confident that it has been arrested by careful attention to the isolation of cases. It is not thought that it had its origin in the admission of cases from outside, for its first subjects were old inmates of the asylum; nor did it appear very evident, as regards the early cases, that it was conveyed by contagion. With but short intervals, cases developed in several different wards. It may, however, be plausibly suggested as regards these, that very possibly the medical attendants or the nurses were themselves the vehicles of the infection. Great attention has recently been paid to washing the hands, &c., with carbolic solutions, which was not done in the first instance. At one time Dr. Knox was inclined to believe that the disease was in some way connected with drinking milk; but this hypothesis

has, I believe, been abandoned. Although many of the cases have been severe, almost the entire surface being involved, yet in some it has been quite slight. Thus Dr. Knox himself and one or two of the nurses have had patches on the face and hands, though they were never sufficiently ill to be disabled for duty. Precisely parallel facts occurred during the epidemic at Paddington.

Thus then, to sum up, I think there can be no doubt that we have in these epidemics a form of dermatitis indistinguishable in its principal features from generalised eczema, but more rapid in its course, and showing a greater tendency to spontaneous recovery. Whilst, however, eczema as a rule shows little or no tendency to spread from person to person, we have here a virulently contagious malady. The febrile disturbance and cedematous swelling of the affected parts, the vesication, temporary crusting and subsequent peeling, are all features in which the disease resembles erysipelas. The malady is much more severe than eczema, and much less severe in a general way than erysipelas. At the same time it is more lasting than the latter, and less so than the former. That its natural and proper position is as a hybrid or connecting link between the two, I can feel little doubt. In support of this proposition I will venture to narrate the particulars of a few other cases taken from private practice, which appear to illustrate similar laws of pathological development.

As regards the absence of this form of disease in the Bethnal Green Infirmary in preceding years, I may note that Dr. Knox expressed himself, in the clearest manner, that it was new to him. He said that he had been at the infirmary many years, and had never before known such an outbreak. On this point I have made some inquiry at other institutions. The result has been a strong impression that cases of diffuse senile eczema are not more common in these infirmaries than they are in private practice, and that very rarely indeed does any suspicion occur as to its spreading by contagion.

During a visit about a year ago at the Lambeth Infirmary, for another purpose, I made inquiry as to the prevalence of eczema and allied forms of dermatitis. Dr. Lloyd, the

resident medical officer, informed me that he always has cases of general eczema in his wards, especially in aged persons. During the summer (1892) he thought he had had more than the average, but his attention would not have been attracted to their prevalence had not others referred to it. He showed me one case of rather unusual severity. The patient was a woman of between fifty and sixty. She had been admitted in August with dropsy, and three days after her admission had begun in "eczema" for the first time in her life. It had spread over the whole surface. When I saw her she was a good example of *Dermatitis universalis* or *Pityriasis rubra*. No portion of her skin was exempt. The nails were affected, though not very severely, and she had lost almost all her hair. The skin was everywhere dry, red, and scaly. She had emaciated considerably. The skin of her palms and soles was thickened. Although the dermatitis was absolutely universal, it was not, when I saw her, of extreme severity. I was told that it had been much worse.

I was not shown any other cases of eczema, and clearly the prevalence of the disease in this infirmary had not approached that which occurred at Paddington and Marylebone, and this summer at Bethnal Green.

*A case illustrating the theory of Erysipelas-Eczema.*

I saw, with Dr. Thyne (December 20, 1892), at Barnet, a very interesting case bearing upon the doctrine of erysipelas-eczema. There are two forms of this disease; one, in which it is symmetrical, attacking simultaneously, or almost so, both sides of the face, and closing the eyelids, and another in which it spreads from a single spot on one side aggressively over to the other. Possibly, however, these two apparently different forms differ really only in stage: the bilateral outbreaks occurring only in those who have had the disease before, and in whom it is frequently recurrent. The case which I am about to describe was a first attack. Our patient was a gentleman, little short of sixty, who had always enjoyed excellent health. His present ailment had commenced about ten days before I saw him, by redness about

the patient that he must go to bed and be systematically treated. The prescription was an antimonial mixture, and a lead and spirit lotion.

After we had finished our consultation, a very interesting fact was elicited. Our patient had averred, in answer to inquiries as to former attacks, that all that he had experienced was once, when in Switzerland, a transitory attack of eczema in one leg, which had soon been completely cured. He subsequently remembered, however, that when a boy at school he had been cut on the top of his head by a piece of stone, and that he had subsequently been in bed several weeks on account of inflammation, spreading from the wound, which ran all over his face and neck. Clearly this had been an attack of traumatic erysipelas. Of the wound he showed us the scar. Although a period of more than forty years had elapsed since this illness, I am not disposed to believe that it was without its influence with reference to the present attack. Erysipelas appears always to leave its germs behind; and many cases have come under my notice in which patients who had once suffered, experienced second attacks after very long intervals. Such second attacks are, I think, always less severe than primary ones.

I do not see that anything could be gained by resisting in such a case as above the diagnosis of a hybrid malady. Beyond all doubt the dermatitis presented the local features and the clinical history of eczema and erysipelas mixed. It required the treatment for erysipelas, and its subsequent course will probably, to a considerable extent, fit with that disease. Yet that the constitutional disturbance attending it was far less than is usual with erysipelas cannot be doubted. Nor, I expect, will the cure prove so rapid or so complete as usual in erysipelas.

I need not here again insist upon the importance of the doctrine of this hybrid malady in reference to the explanation of eczema epidemics; concerning these I have already written fully. I may, however, just remind my readers that in many of these cases the disease began by a local patch, and then spread by auto-infection over the whole body. Some of the cases were attended with considerable constitutional dis-

## ~~SYMPTOMS~~ OF ECZEMA-ERYSIPELAS.

... ~~and~~ ended fatally. Yet the disease was  
... in most of its characters. I suspect  
... rule, when eczema shows a tendency to  
... contagion and become universal, and especially  
... contagious to other persons, it partakes not only  
... features, but of the real nature of erysipelas.  
... face of a large body of clinical evidence which  
... the contrary, we should persist in clinging to the  
... erysipelas is a specific fever and always keeps to  
... I may confess that I cannot see. The doctrine of its  
... origin would not be endangered by a more elastic  
... Whenever any form of inflammation becomes con-  
... and yet keeps to its type, we may freely admit the  
... that there is present some living organism by  
... the contagion is effected. Whilst, however, in all  
... departments of biology our conceptions of what con-  
... specificity are receiving liberal modification, it seems  
... doubtful wisdom, when dealing with the causes of disease  
... supposed to be specific, to trammel our thoughts by arbitrary  
... limitations which the future may probably prove to have had  
... no sound foundation.

## SCROFULOUS ULCERS ON THE LEGS (BAZIN'S MALADY).

THE attention of dermatologists, both in London and in Paris, has been of late directed to an important class of cases in which multiple ulcers occur on the legs of young persons, and assume features which might easily be mistaken for those characteristic of syphilis. A description written by M. Bazin many years ago, and which had been forgotten, has been found to apply with considerable accuracy to some at least of these cases. This distinguished observer named the malady *Erythème induré des scrophuleux*, and wrote of it under that name in some detail. Whilst, however, he fully recognised some of the principal features of the malady, it may be objected to the name which he gave that it does not designate the most prominent of them, that is the ulceration. These cases are of great importance, not alone on account of the difficulties in their treatment, but because, from their close resemblance to syphilis, they may easily give rise to unfounded suspicions and induce the adoption of uncalled-for medication. I may freely confess that in former years I have myself been led into error, and at the present time, with the exception of those who have paid especial attention to the subject, I believe that the diagnosis of syphilis is the one almost invariably made and acted upon.

I purpose on the present occasion to narrate as briefly and explicitly as I can my own experience in respect to these cases; but, before doing so, it is right that I should say that I am specially indebted to Dr. Colcott Fox for having called my attention to M. Bazin's description,\* and for having shown

\* The following translations are from Dr. Fox's pen:—"In second edition, 1861, of '*Leçons sur la Scrofule*,' Bazin writes as follows: '*Erythema indurata*, of scrophulous nature, is not rare; it is characterised by red plaques, indurated,



me several instructive cases. I have also had the opportunity of examining several subjects of the malady, who have been presented by different members of the Dermatological Society at its meetings. I have also seen cases in the Paris hospitals, and one excellent example under Professor Neumann in the wards of the General Infirmary at Vienna. I make these statements here as a matter of justice to others, and because,

upon which the finger, when applied momentarily, makes the redness disappear, to quickly return in a few moments. One feels on and under the skin an induration which sinks more or less deeply into the subcutaneous connective tissue. The redness, more or less dark, pretty often violaceous, more marked at the centre, blends insensibly with the normal colour of the skin. There is no itching upon these plaques; pressure with the finger is hardly painful. This affection is observed commonly upon the legs, more often perhaps in girls than in boys. I have often met with it upon the legs of young washerwomen, in young girls offering all the attributes of the "*fraîcheur et embonpoint scrofuloux*." The seat of predilection is the external and inferior part of the leg. One sees it sometimes also situated a little above the heel along the tendo Achillis. Lastly, one can observe it also on the face, and I have seen it upon this region alternate with scrophulous ophthalmia.' On page 193 he varies his description with regard to the colouring, and states that the colour is the same upon all the extent of the plaque, the induration is equal, and pressure is painless. At page 501 he records a case in detail, observed in a washerwoman in 1858, and of six months' duration. The lesions did not ulcerate, were not painful to pressure, like those of erythema nodosum, nor was there the play of colours observable in the latter affection. The woman was in hospital for six weeks, and was treated by Tisane of Hop and Syrup of Iodide of Iron, internally; by starch baths, and later by sulphur baths, externally; but was not completely cured on discharge. The year previous, in his '*Leçons sur les Affections Cutanées de Nature Arthritiques et Dartreuses*,' 1860, page 98, Bazin also writes thus: '*Scrofulous Erythema manifests itself in patients who have a soft constitution and the lymphatic temperament. It is characterised by a plaque, usually single, of a vinous red, larger than the taches observed in Erythema Nodosum, situated at the anterior or external part of the legs, not painful, constituted by an uniform induration which is limited to the skin, and does not extend into the connective tissue.*'"

I venture to propose that these cases should for convenience sake be known under the name of Scrofulous Ulcers on the Legs, or Bazin's Malady. To call them Indurated Erythema, when by far the most marked feature is ulceration, will lead to nothing but misconception. Although Bazin would appear to have observed only the earliest stage of the malady, and possibly failed to connect the ulcer cases with it, yet there can be no doubt that his description, so far as it goes, does apply to the cases with which we are dealing. He is quite correct in what he has written as to the class of patients attacked and the probable etiology of the malady. It is curious, however, that he should deny the implication of the subcutaneous cellular tissue. In this I cannot agree with him.

it is my intention, as usual, in what I am about to write, to keep closely to my own facts.

The reader may find at page 58 of Vol. I. of ARCHIVES the narration of a case of large ulcers, on the leg of a girl, looking like syphilis. Specific history absent. This was a case sent to me by Dr. Dukes, of Rugby, and it differed a little from the more typical examples of the affection, in that only one lower limb was affected, and in that a large ulcer on the back of the thigh had preceded those on the legs. In a paragraph appended to the report of this case I have briefly mentioned a second one, which was under my care at the same time, and in which both legs were affected. At the time that this short paper was written, I was in ignorance of M. Bazin's description, nor did I know that the subject was attracting attention amongst my colleagues either in Paris or at home. As a matter of fact, I believe that the London observations commenced at about that time, those at the Hopital St. Louis somewhat earlier. The conclusion at which I arrived respecting the two cases referred to, was "that the conditions assumed depended upon feebleness of circulation and individual peculiarity, and not upon specific taint." One of the two patients to whose cases I refer, subsequently got quite well under Dr. Dukes' treatment at Rugby; the other, one of the most severe that I have ever seen, did not improve quickly under treatment, and was lost sight of after a few attendances. The reader will find recorded in my little book on Syphilis, at page 351, two very remarkable cases in which adult married women were the subjects of these ulcers, and in which I was much puzzled to decide whether they should be considered syphilitic or not. The cases were under my care in 1885, and one of them has remained so at intervals ever since. My subsequent observation of these and of other cases obliges me to believe that neither of them had any relation to syphilis. Both of them had been pronounced to be syphilitic, and were brought to me with that diagnosis. This, indeed, has been the suspicion in most of the cases that have come under my care. It is, as I have said, the liability to this error which constitutes one of the most important features of the group. In the report to

which I refer (see page 355) I have also recorded a case of a healthy-looking married man aged 54, in whom the history of syphilis was wholly wanting, and both of whose legs were covered with ulcers exactly like those to which I refer. I may remark, in connection with this case, that the patient was very much older than in any other which I have seen. As a rule, the affection is one of childhood or adolescence. A very important point for investigation in connection with these cases is the question as to how far and in what sense they are to be considered as scrofulous. To this it will be seen in the following narratives I have given special attention, not so much, I may admit, by search for the bacillus as by careful inquiry as to family history. In certain cases undoubtedly these ulcerated legs are found in association with other manifestations of a strumous kind, but in not a few no such association can be proved. Although it is quite certain that the local process is an infective one, and that one ulcer becomes the parent of others near to it, yet the escape of the lymphatic glands in the groin is, I think, an invariable and noteworthy fact. In no single case which has as yet come under my observation, have I witnessed the development of any definitely tuberculous affection.

As regards the initial lesion, it is not always the same. I may quote the following sentence from what I wrote in 1887 (see page 355): "I carefully studied the initial lesion in these cases, more especially in that of Mrs. D——. It did not appear to be always the same, consisting in some instances of an indurated knot under the skin, possibly around a vein or lymphatic; and in others of a large and very slowly progressive lichenoid tubercle, developed around a hair follicle. After ulceration had taken place, the sores always tended to the formation of low rupial scabs." It is quite possible that the two conditions mentioned may be co-existent only in the later stages of the disease, and that the subcutaneous knots, which are in all well-developed cases such a marked feature, are really secondary and the result of infection from an ulcerated lichenoid tubercle. When the condition shows itself on other parts of the body, as, for instance, on the backs of the upper arms, it is always in the form of lichenoid papules, and never

attended with subcutaneous knots. I have only seen the face implicated in a single case, and in that the condition was one of ulcerated acne. These facts lend support to the view that the beginning of the disease is usually in the hair follicles and their adjuncts.

The size of the ulcers may vary very much. Usually they are only small, such, for instance, as might contain the half of a hazel nut; but some of them are often very much larger, and may be an inch and a half or two inches across. They clearly spread by infection of their edges, and may thus, if neglected, attain almost any dimensions. I possess four portraits illustrating the condition under discussion, one of them of a child in Dr. Langdon Down's Asylum at Normansfield; one that of Master R—; a third from a patient shown me by Dr. Colcott Fox; and a fourth a Miss —, who was sent to me by Dr. Hughlings Jackson.\* These portraits can all be seen at any time, in my Clinical Museum, by any one interested in the question. I may just remark that several of my patients were girls, who, for epilepsy or other maladies, had taken bromides or borax. On the other hand, in other cases there was no history whatever of the use of any drug of this class.

In my early cases I tried many different methods of treatment, and laid particular stress on confinement to a recumbent posture. I have found, however, that the latter measure is by no means always needful, and I have recently cured several cases while allowing the patient to walk about. An ointment containing four or five grains of the Bisulphuret of Mercury to the ounce is, according to my experience, almost a specific, and exceeds in value all other measures. All drugs which lower tone should be carefully avoided. Tonics and purgatives should be given, and, if possible, the patient should be sent to the seaside. I will now proceed to the narration of some cases which illustrate my general description.

*CASE I.—Ulcers in the legs in a girl—Tuberculous family history.*

The subject of this case was a delicate-looking girl of thirteen. Her teeth were bad in the sense of being decayed and discoloured, but they

\* I purpose in my next ARCHIVES to reproduce some of these.

showed nothing suggestive of inherited taint. The upper incisors in particular were large and well formed. There were some enlarged glands on each side of the neck. The child was the youngest of a family of nine, of whom only four were living. There was suspicious history of tubercular developments in several of her relatives. She herself had never been strong. She had many ulcers on both legs. They were exactly of the character of those described in the other cases. Their location, size, &c., are well shown in a sketch taken by Mr. Swainson. Those on the back of the legs were ragged with undermined edges, and presented appearances which would at once suggest the diagnosis of specific disease. It was said that the ulcers on the legs began four months ago.

CASE II.—*Ulcers of the legs in a girl—History of a former attack.*

I saw Miss S——, a girl aged 16½, in September, in 1891, in consultation with Dr. Brockwell and Mr. Gandy. She was of a fair, florid complexion, and had a feeble circulation, but was not liable to chilblains. She was suffering from ulcers on the legs, of which wide undermining of the edges was the chief characteristic. There was a large scar on one leg; quite sound, but with a red edge at one part. The skin of the legs and the subcutaneous tissue were rather thick and pale. The sores were believed to have arisen from midges' bites, and had been made worse by standing. Four years previously she had had a similar attack, and had got quite well. Rest on her couch, a mercurial ointment, and the india-rubber bandage were the measures adopted, and were quite successful.

CASE III.—*Cachectic Ulcers in the leg of a young lady—Prolonged previous use of bromides.*

Dr. Hughlings Jackson was kind enough to send to me a young lady who had been for long under treatment for epilepsy, and in whom unhealthy ulcers on the legs had recently formed.

Miss L—— was 21 years of age, well grown, and of healthy aspect. She had suffered from epilepsy for some years, and taken bromide of potassium, on and off and in varying doses, almost the whole time. She was still taking it. It had not wholly controlled the epileptic tendency, but it had not in any way disagreed, so far as could be observed. She had never had any bromide-acne or other eruptions.

The ulcers on the leg were three in number and all on the lower part of the left leg, but at some little distance from each other. The largest, which was as big as a florin, deep, with abrupt edges, and all but phagedenic, was on the back of the leg. One of the others was in front, and one on the side. The intervening skin was quite healthy and uninfamed. The condition of the largest of the ulcers is well shown in a portrait which was taken. It was almost exactly like that present in Dr. Dukes' case, published at p. 48 of Vol. I. of ARCHIVES.

I was obliged to advise in this case that the bromide should be given up, as it seemed very possible that it might be reducing the vitality of the tissues. Dr. Jackson very reasonably protested that the bromide was given at the Hospital for Epilepsy by the pound, and that no cachectic ulcers on the legs were ever observed in consequence of its use. He, however, consented to the substitution of borax.

On February 7th I gave up the prescription of borax, and prescribed nepenthe in *mij ter die.*, and *nux vomica* with *cascara*. The sores were dressed with a mercurial ointment.

In March the leg was wonderfully better: one sore being healed, and the others covered with florid granulations.

I subsequently saw this young lady in lodgings at Southend. She had much improved in general health, and the only remaining ulcer on the leg was almost healed. The bromide had been entirely disused for some time. No fresh epilepsy had occurred, but her mother thought that she was threatened. I do not know the final result of the case, not having seen the patient for several years.

#### CASE IV.—*Unhealthy Infective Ulcers on the legs of a young woman in good health—Cure.*

A remarkable instance of the kind of sores which I have been describing occurred in the person of a very healthy young lady, who was brought to me by Dr. H——. She was twenty years of age, and, excepting that she suffered from cold extremities, no departure from perfectly good health could be made out. She was of active habits and cheerful disposition. Her mother gave me a full account of her life history. She had suffered from typhoid fever eight years ago, and from measles six years ago, but no special ill consequences had followed either. On June 24, 1889, she went to a cold swimming bath in London, and was, she believed, bitten by some insect. Several little irritable tubercles formed, some on the backs of her arms, one on a shoulder, and three on the left leg. With the exception of those on the leg, all had disappeared before I saw her. Those on the leg had passed into peculiarly unhealthy looking ulcers. I saw her first on September 18th, just about three months from the beginning. During the interval, various very judicious measures had been adopted, both local and general, and amongst them a visit to the seaside. Dr. H—— had prescribed iodoform, and under its influence the sores had looked at one time as if they would heal; a relapse had, however, occurred. When I saw Miss R—— there were three sores close to each other upon the front of the right leg. They had swollen and rather livid edges, and their surfaces were destitute of granulations, and covered with grey secretion. They were none of them bigger than sixpences, and it was their peculiarly indolent and unhealthy character, rather than their size, which attracted attention. I was told that in the first instance there had only been one, and thus it appeared probable that something of the nature of an infective process was at

work. Dr. H—— and I agreed to have the sores cauterised with the acid nitrate of mercury, and to insist on the legs being rested in an elevated position. After a fortnight of this treatment, however, not the slightest benefit had been obtained. On the other hand, two little indurations had formed in the adjacent skin, which were threatening to break down into new ulcers. I now recommended that Miss R—— should again be taken to the seaside, and that the use of liquor arsenicalis should be tried as an application in conjunction with complete rest. I also prescribed small doses of mercury internally in combination with tonics. We were already using mercurial ointments, and carefully keeping the foot warm.

At a subsequent visit I wrote: "I feel quite sure from what I have seen to-day that the nature of the process in Miss R——'s legs is an infectious inflammation of the cellular tissue. Near the margins of the ulcers flat areas of redness with slight swelling form, in the centre of which, after a week or ten days, softening takes place. The place finally ulcerates, and then a thin yellow patch of necrotic cellular tissue is exposed. This is the condition present to-day in a new ulcer which has formed during the last week. Whilst it has been forming the old ones have been healing, and some have quite healed, others show healthy granulations. The nitrate of silver, ten grains to the ounce, seems to suit best for the open sores. Miss R—— is staying at Worthing, and is in excellent health. I find that she never took a dose of bromide in her life. The process of spreading by subcutaneous infection seems to be just like that which occurs in cases of diabetes."

CASE V.—*Multiple Ulcers in the legs in an adult male—Feeble circulation—No syphilis.*

A patient who was brought to me by Dr. Barlow in November, 1892, offers another example of these peculiar ulcers in the legs, and one in which they occurred under somewhat exceptional circumstances. A Mr. H——, a gentleman from Yorkshire, aged 36, knew of no other morbid inheritance in his family excepting that of gout. From gout his grandfather and several of his uncles had suffered repeatedly. His father, who came with him, was a hale man of 70, and had never had gout. Mr. H—— himself had, at the early age of 28, or sooner, become the subject of Dupuytren's contraction of the palmar fascia. This contraction had developed almost to an acute affection, and his little and ring fingers, first in one hand and then in the other, had been drawn down into the palm. Some operation had been done in the left hand, and it had resulted in the amputation of the little finger.

When aged 30, Mr. H—— had suffered from troublesome inflammation about the right ramus of lower jaw. A succession of abscesses were opened, and of these all that now remained were some long, perfectly sound scars. Mr. H——, although a vigorous man, and formerly an

active football-player, had always been liable to suffer from cold in the extremities and feeble circulation. He had never had chilblains. He had never had actual gout, nor anything definite in the way of rheumatism, but the last joints of several of his fingers were very definitely enlarged, and in one of these was a slight displacement. Dr. Barlow told me that when he first saw him in 1886, his aspect suggested an unfavourable opinion as to his prospects; and he still looked puffy and pale, though he was not definitely ill.

I now come to describe the conditions for which I was consulted. During the last two years, Mr. H—— had suffered from troublesome ulcerations on his legs. His left leg had been first attacked, and had got well, numerous scars being left. His right was still affected, and showed two ulcers exactly like some of those which I have described in the preceding cases. One of these was large enough to hold a half-walnut: it had overhanging, ragged edges, and a general condition so unhealthy as to be suggestive of phagedæna. It would certainly have been taken in former days, from its appearance only, as conclusively syphilitic. There was, however, no history of syphilis, and, as I have said, the ulcer did not exceed in its suspicious characters several others which I have described in cases in which the negative evidence was yet more conclusive than in this. Mr. H——'s legs were not œdematous, but they were thick and somewhat shapeless from excess of cellular tissue, in this respect resembling the legs of young women who suffer from feeble circulation, more than those of a man.

It should be noted that he had an excess of subcutaneous cellular tissue generally. There were a few, slightly marked, small varicose veins on his legs, but nothing of any importance. Near the root of his penis, attached to the fascia of the right corpus cavernosus, there was a very hard lump as big as a horse-bean, probably a calcified phlebolith. It gave him, he said, no inconvenience, and he knew not exactly how it had formed.

We have in this case, I think, an example of a definite partnership between gout, scrofula, and feeble circulation. Although there was no known history of tuberculosis in the patient's family, yet the attack of ophthalmia in childhood, and the abscesses about the jaw at the age of 30, were probably of a strumous nature. As such, also, I should regard the ulcers on the legs. The explanation of the contraction of the palmar fascia and of the acro-arthritis are to be found in the inherited liability to gout.

#### CASE VI.—*Ulcers on the legs and arms in a child—Inherited Syphilis suspected, but doubtful.*

Dr. Langdon Down brought to me a girl ten years old, who was under his care, as a speechless idiot, at Normansfield. She had in early infancy suffered very severely from convulsions. Although she was well grown, and could use her limbs fairly, she was quite unable to speak. It had been supposed that she was the subject of specific disease, but of this I



could find no evidence. Her teeth were perfectly well formed. Through the whole of her life she had at intervals taken bromides very freely. Quite recently her general health had failed, but until within the last few months, Dr. Down assured me that she had been florid and in good spirits. She was brought to me on account of what had been considered subcutaneous gummata on her legs and the backs of her arms. These had been present during the last six months. It was thought that they had already been benefited by the internal use of mercury, but her legs were still covered with sores. I had a portrait taken of the legs, which I now copy [see next number of ARCHIVES], and which will enable my readers better to realise their state than any description which I can give. They were covered with small ulcers, many of which were still crusted over. Some of them presented, more or less, a papillary growth. There was little inflammation of the intervening portions of skin. On the backs of the upper arms there were a few little lichenoid pustules and one or two ulcers, with a certain amount of papillary growth. The conditions differed a little from those most usual in this class of case, in that the ulcers in many cases presented a raised surface caused by granulation growth. In this respect they reminded me much of the conditions consequent on the bromides and iodides, and were less suspicious as regards tuberculosis. I thought it very likely that the case was complicated by depraved nutrition consequent on the drug treatment.

CASE VII.—*Ulcers on the legs, in a young lady, resembling Syphilis—Some suspicious facts in her history, but final diagnosis negative.*

A case which was unusually perplexing presented itself on November 19, 1890. Miss B——, a very tall, good-looking girl of 16, looking like 19, had both legs covered with ulcers and scars. The ulcers were some of them deep and punched out, and the scars had pigmented edges. Altogether the legs might have been deemed typical of syphilis. She had also some thickening over the shins, and the bone appeared to be distinctly tender. I am prevented from speaking with certainty on this point, because there was some swelling of cellular tissue, and she was rather hyperæsthetic. She was the only surviving child of seven. In further confirmation of the suspicion of inherited syphilis, she had twice been laid up with inflammation of her eyes—once when æt. 6, and a second time æt. 10. Of these attacks all traces had disappeared.

Miss B——'s front teeth were of good form; some of the others showed stomatitis changes. Her forehead was a little suspicious, but her complexion, as already stated, was clear, and showed nothing peculiar. She had always suffered much from cold extremities, and the cheek coloration was circumscribed. On the backs of her upper arms were many little scars, the results of small ulcers from acne (cacatrophia

folliculorum). There were also, both here and on the backs of the fore-arms, numerous little subcutaneous abscesses of an indolent character.

Her mother stated that as a baby she was quite healthy (but took Steedman's teething powders). Until six years old she was quite well; then occurred a three months' attack of inflammation of both eyes.

Of the six infants which had died, all are said to have suffered in the same way from jaundice; "all became the colour of an orange within a few hours of birth." Three lived only three days; the other three lived a few months. In three of them autopsies were performed, and the doctor said that they were exactly alike—"enlarged liver." Two of the three which lived longer suffered all the time from diarrhoea and other affections. One recovered perfectly, and died, after a few days' illness, of inflammation of the lungs, *æt.* 18 months.

Both parents are living, and neither have had any special ailment, excepting asthma in the mother. The mother has suffered from childhood from recurrent herpes inside the lips and on tongue.

Miss B——'s eruption began by small spots on the backs of the arms six years ago, and a year or two later ulcers on the legs showed themselves. At one time she had an ulcer on the right leg as big as the palm of a hand, and which her surgeon describes as a sloughing ulcer. Menstruation began only eighteen months ago. She never had a chilblain.

Careful examination of the eyes after atropine did not reveal any traces of keratitis or of choroiditis. Some small opacities at the edges of the cornea made it probable that the attacks of inflammation of the eyes had been of a pustular character.

In March, 1898, I heard from Miss B——'s surgeon that she had completely recovered. Specific treatment had been tried, but proved useless; and improvement had begun soon after calcium sulphide was given. She got quite well after a few weeks, and had remained so ever since, with the exception of a few spots in the following spring. There had also been an eruption of a few papules, which had not broken down, and were going away at the time he wrote.

#### CASE VIII.—*Multiple Ulcers on the legs preceded by Vesications* —*History of three attacks—Gland-Struma.*

A girl whom I saw with Mr. Gervis, of Haverstock Hill, presented a good example of the kind of ulcers which I have described, and in association with conditions implying definite struma. She had a considerable mass of enlarged glands in the right side of her neck. On my noticing these, her mother at once showed her own neck, which was scarred by gland abscesses, from which she had suffered in early life. No trace of enlargement (in the mother's neck) now remained.

Miss G—— was a fair-complexioned, well-grown girl of 17, with rather an excess of subcutaneous tissues. The backs of her upper arms were rough with enlarged follicles, but did not show any sores. Both her

The first of these is the fact that the  
 number of people who are employed in the  
 service of the government is increasing  
 rapidly. This is due to the fact that  
 the government is expanding its activities  
 in many fields, and is therefore  
 requiring more personnel to carry out  
 its functions. This is particularly  
 true in the case of the armed forces,  
 where the number of personnel is  
 increasing at a rapid rate. This is  
 also true in the case of the civil  
 service, where the number of personnel  
 is also increasing rapidly. This is  
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 of the civil service, where the number  
 of personnel is also increasing rapidly.

## ON CANCER AND NEW GROWTHS.

(Continued from Vol. IV., page 65.)

### *On the Early Diagnosis of Epithelial Cancer.*

I will venture a few remarks on the diagnosis of Cancers which begin on or near the surface, for the most part varieties of Epithelioma. We rarely see them until ulceration has set in, and the problem before us is, usually, to distinguish them from common inflammation, from papiloma, from lupus, and from syphilis. Of these the last is by very far the most important, whether we regard its frequency or the closeness with which it simulates malignant disease. Nine-tenths probably of the mistakes in the recognition of epithelial cancer are made by mistaking for syphilis an ulcer which is really malignant. A few errors of a converse kind are made, but they are of infrequent occurrence, and of trivial ill consequence, whereas errors in the former direction are of everyday experience, and often lead to fatal results.

Growth and ulceration co-existing, that is growth followed by ulceration, are the conditions by which we chiefly recognize epithelial cancer. The points to which we should chiefly attend are these: Is there proof not merely of inflammatory infiltration or of granulation masses, but of something which deserves the name of growth, whether infiltrating the base or sprouting up from the edges, and is there with this a tendency on the part of the new product to break down and die? These are the questions which we have to decide. If we can feel confident in these, we have usually made our diagnosis. The disease is cancer. I put aside a number of minor symptoms, such as the state of the surface, the pain caused or its absence, the state of the lymphatic glands, and say, simply: Convince me that there is growth with ulcera-

tion, and I will not ask for more upon which to base my recommendations. The other symptoms as often hinder as help. More especially permit me to denounce the imbecile habit of trusting for guidance to the state of the lymphatic glands. In syphilitic tertiary ulcers the lymphatic glands are not enlarged, but in cancer they are—so say certain text-books which ought to know better. The fact is, of course, correct; the absurdity—I had almost used a stronger word—lies in suggesting that the practitioner should wait until the glands are large before he ventures to make his diagnosis. If he so waits—and many do—he delays his treatment until it can scarcely by possibility be of use. We must make our diagnosis of cancer before we have any help from the state of the lymphatics, or we are indeed blind leaders of the blind.

*Rodent Cancer of the face beginning at the age of fourteen—  
History of the same disease in the father of the patient.*

The subject of the following case was a young man of twenty-five, who had a well-characterized rodent cancer on his cheek and the side of his nose. Two operations had been done before I saw him. The patient was subsequently admitted into the London Hospital, where my son excised the disease and did a large transplantation of skin. The diagnosis was fully verified by the microscope. The following notes describe his condition when he consulted me:—

The right side of his nose, and the adjacent part of his cheek and lower eyelid, as far as the level of the outer canthus, are occupied by a superficial ulcer, which presents in several parts a sound, smooth cicatrix. The ulceration involves the inner canthus, and passes downwards on the side of the nose to within a third of an inch of the edge of the ala. The edge of the ulcer is not quite continuous, being broken by healthy scar at several parts. The ulceration is deepest at the lower part of the ala. At the deepest part the ulceration has a sharply marked edge, and is an eighth of an inch in depth. Its surface at this point presents a greyish secretion and is unhealthy. At most other parts the edge of the ulcer




## PLATE CXI.

### RODENT CANCER IN A YOUNG MAN.

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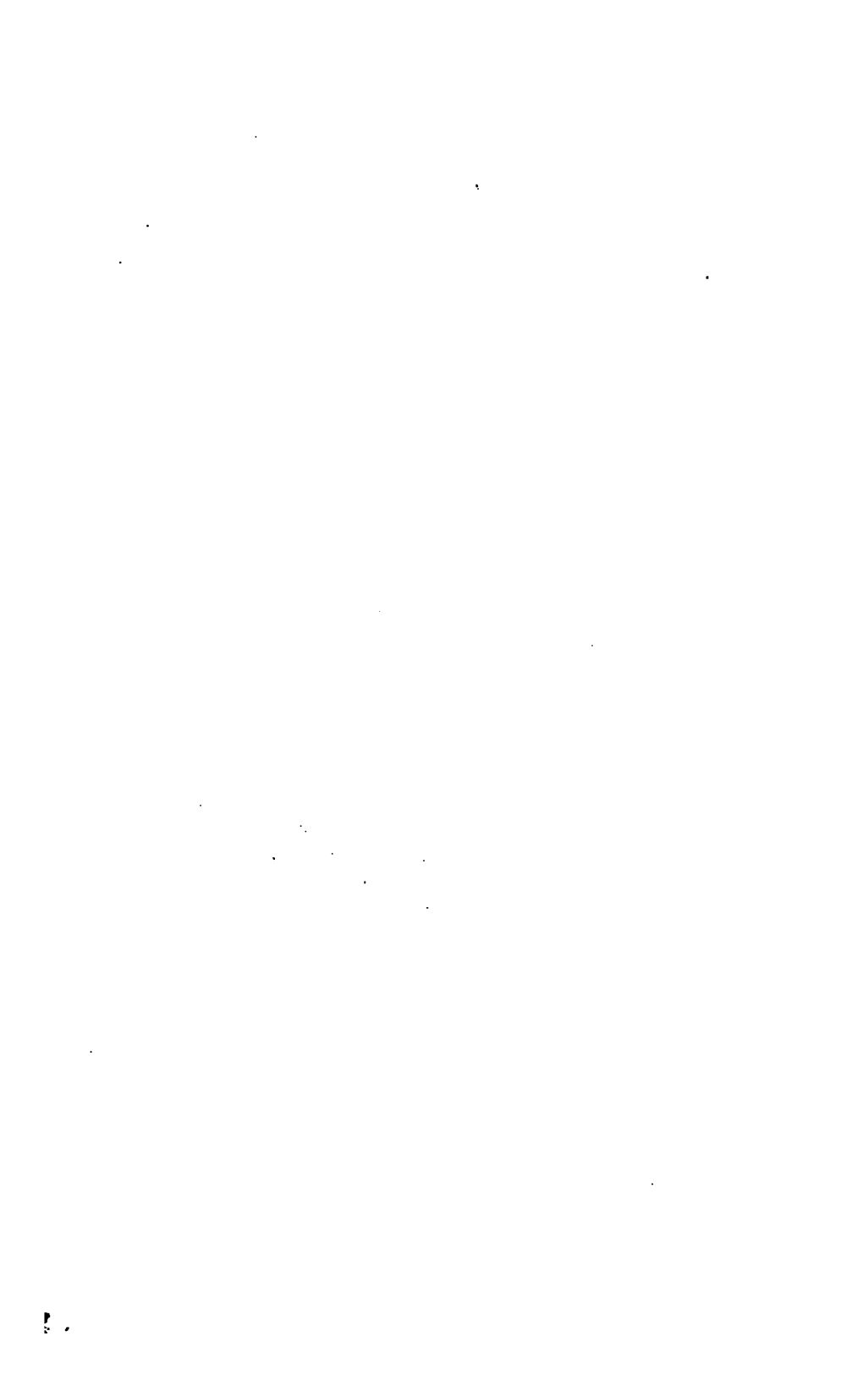
THIS portrait belongs to the case reported at page 44 of the last number of 'Archives.' It exhibits a well characterised rodent ulcer with a hard, rolled, sinuous border, which had been spreading for nearly ten years in a man, who, at the time the portrait was taken, was only twenty-five. It had been twice excised, and had twice recurred. A most interesting point in the history of the case is that the young man's father had been the subject of rodent cancer for many years before his son's birth. He (the father) died of the disease thirty years after its commencement, with the greater part of his face eaten away.

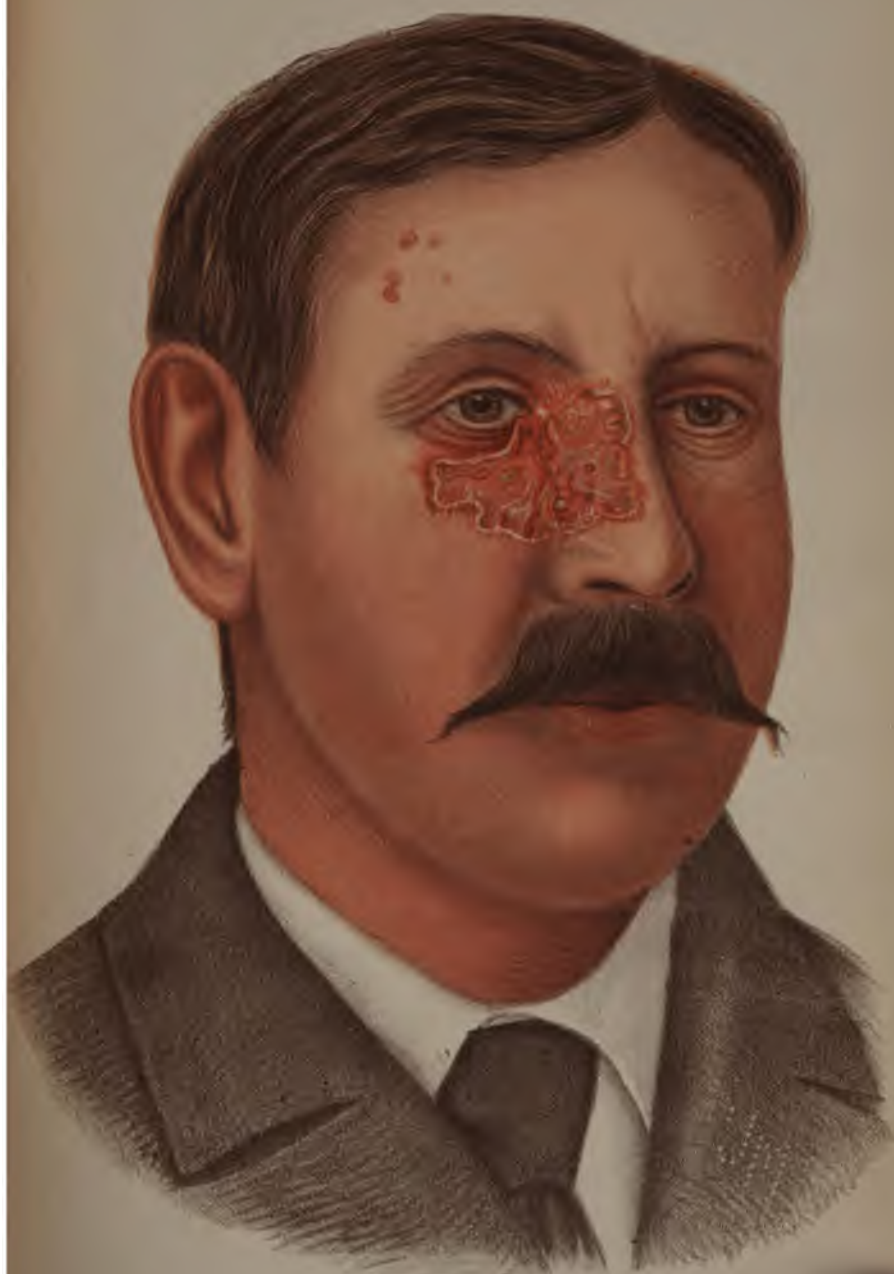
In the present case my son performed a third operation, freely excising the growth, and transplanting on to the wound a large flap of skin from the forehead. The result appeared to be very satisfactory when the patient was last seen, but it is much to be feared that the disease will sooner or later return.













is simply a slightly marked sinuous roll of induration, with scar on the one side, and healthy skin on the other. By this I mean that there is scarcely any ulceration. The disease, for the most part, consisting in an advancing border of growth which is followed immediately by scar. The character of the induration, and its being made up of little crescentic portions which have coalesced, is quite characteristic of rodent cancer. The interesting points are that the disease began at the early age of 14, and was, according to the young man's description, at the age of 20 well characterized and considerably advanced. It is further to be added that his father died of rodent cancer which had eaten away the greater part of his face, and had been in progress thirty years. He was 69 when he died, and, according to him, the disease must have been considerably advanced before his son was begot.

This case is a striking illustration of the general law, that if cancerous action manifest itself in young persons, it is usually hereditary. That form of epithelial cancer, which was formerly known as rodent ulcer, is very common in old age, and may happen to those in whom there is no family proclivity. It is very unusual in those under 30, yet we have here an instance of its commencing in some sort at 15, and being quite well characterized at 20. The subject of the case was the son of a man who had died of the same disease, and he was born at a time when the disease had already been present in his father for many years.

The next case illustrates the same point.

*Rodent Cancer beginning almost from childhood, with history of Cancer of the Scalp in the patient's mother.*

A woman named D—, aged 42, who came to me from L—, with a rodent ulcer on her left cheek, gave the history that she had had a sore or wart almost from childhood. It had been an open ulcer for twelve years at least, and had been called lupus. It had been several times operated on.

It was a well-characterized rodent, with some masses of firm fungating granulations. Her history was that her mother had died of a malignant ulcer in her scalp, æt. 70.

*Proposed rule for prognosis in cases of Cancer suited for operation.*

Mr. Thomas Paget (of Leicester), writing in February, 1850, suggested as a rule in the prognosis of cancer cases that the chance of relief from operation is in inverse ratio to the rate of progress previously shown by the disease. There is of course much truth in this, but at the same time there is an important fallacy. The rule cuts both ways. Slow-growing tumours are precisely those in which operations may with comparative safety be avoided altogether. Thus a slow-growing scirrhus in an elderly person may not infrequently be left, without interference, in the confident belief that it will not shorten the patient's life. The greatest triumphs of operative surgery in cancer occur in cases in which the operation is done early for the growths which are rapidly increasing. Of such I could mention many examples.

*Tumour of ten years' growth in the Orbit of a young man.*

Mr. T. Paget, in illustration of the surgical rule above referred to, records a very interesting case in which he removed a large tumour from the orbit of a young man aged nineteen. The tumour had been growing for ten years, and had pushed out the eye, so that, as stated, it was three inches in front of its natural level. Mr. Paget emptied the orbit, and states that "all present concurred in the malignant nature of the tumour, which now forms a specimen in our museum (bottle 47)." \* This patient was alive and quite well five years after the operation. Now taking the fact of ten years' growth and five years' complete immunity after its removal into due consideration, it is certain that the term "malignant" in this case must be accepted with some reservation. A growth of cavernous and fibroid structure is met with occasionally in the bottom of the orbit in young persons, which causes proptosis in the manner described by Mr. Paget and which is not malignant. I possess an excellent drawing

\* Mr. Paget's case interested me so much that I inquired at the Leicester Hospital whether bottle 47 could be found, with a view to further examination of the tumour. Unfortunately it is not forthcoming.

of such a growth from a case apparently quite parallel to Mr. Paget's. In it also the patient was a young man, and the tumour had been growing slowly. If, however, we reject this case as no illustration of Mr. Paget's rule, since probably the tumour was not malignant, we can by no means do the same with the following.

*Long immunity after Excision of the breast in a late stage.*

Amongst the other cases mentioned by Mr. Paget in illustration of his statement that tumours of slow growth are peculiarly favourable for removal, he gives that of the wife of a surgeon, the subject of cancer of the breast, who had for some years concealed her disease. "The scirrhus tumour, when I saw it, had attained such a size and state as together with a large axillary gland made the operation one of the boldest steps I ever advised in this disease. The length of time, however, gave me courage; an extensive excision was made, the wound healed, and she lived in comparative ease an active life for twelve years." The death was finally with signs of internal cancer affecting the pleura and some nodules in the skin.

This is certainly a very encouraging case, and may very properly be allowed weight under parallel circumstances. We come, however, I think, to the common-sense conclusion that in the main the rate of progress in the past is often a good criterion of the probable rate of progress in the future. This applies whether an operation be done or not. In favour of operations in late cases, however, and supporting Mr. Paget's suggested rule, we have the important law that the growth of tumours resembles the increase of population, and is fastest in those which are largest. Thus, a tumour which may have taken a long time in arriving at a certain stage, may take a comparatively short one in completing its career.

*Melanotic Growths on the Thoracic Organs of a Horse*  
(Plate XCV.)

The parts represented in the appended Plate are the thoracic viscera of a horse. I have copied it from an illustration in the "Veterinary Record" for 1846 by Mr. J. Veson.

My object in reproducing it is to illustrate the wide diffusion which melanotic sarcoma finally assumes. In Mr. Oliver Pemberton's work on Melanosis some not dissimilar illustrations will be found, taken from the human subject, and most of our museums contain specimens demonstrating the same facts. I do not, however, know of any which exhibit them in quite such a graphic manner as does the engraving which I have here copied. It will be seen that the visceral pleura is covered with black nodules of various sizes, perfectly smooth, and many of them quite isolated and without any infiltration of the parts on which they grow. Most of them are sessile, but some are arranged like bunches of grapes. The account of the post-mortem states that the parietes of the chest, especially near the attachment of the diaphragm, was studded over with jet black tumours exactly like those here shown. The liver also contained melanotic growths, and there were many tumours on the external part of the body. It will be seen that the heart itself and the pericardium are apparently free from disease. The mass represented between the heart and trachea is described as a tumour, and had not improbably sprung, in part at least, from the mediastinal glands. The subject of the case was an old grey horse. The symptoms displayed during life had been supposed to be those of heart disease, attended with great distension of the veins of the head and neck. No search appears to have been made for the primary growth. This, no doubt, had been on some part of the surface, and very probably near to the anus; this being the common site for melanotic moles in grey horses.





11

## DISEASES OF THE NERVOUS SYSTEM.

### No. L.—*Notes on Rigors and Perspiration.*

It might be well worth while to study in some detail the conditions under which liability to shiver and to perspire occurs independently of the ague poison. In the ague paroxysm, and in the rigor of pyæmia, which closely resembles it, there is first a period of arterial spasm, attended by pallor and lividity; after which follows a sense of surface-heat which is finally relieved by perspiration. These constitute the well-known cold stage, hot stage, and sweating stage, and they are probably essential parts of all rigors. They may vary so much in their duration that it is quite possible that in some cases the first and second stages may be wholly overlooked, and perspiration may be the only one noticed. This probably occurs when persons describe themselves as "liable to break out into perspiration on any slight nervous shock." A narrow escape from being run over in the street, for instance, may within a minute or two be followed by perspiration, and the fact that this was preceded by first a sense of chilliness and then one of great heat, may, on account of the short duration of the phenomena, be entirely overlooked, if the person be not very carefully self-observant.

In some persons, out of tone, the act of digestion, especially in its earliest stage, is productive of a tendency to rigor. Possibly most persons feel a little chilly after a full meal, especially if it has been taken quickly and if no diffusible stimulant have accompanied it. Special complaint as regards this symptom is sometimes made by patients. I have in my mind the case of an old gentleman (Mr. H——`

who used to complain bitterly that after his meals he was liable to shiver and to sweat. He was in a condition of senile want of tone, and had a weak heart and some disease of the arteries generally.

In reference to the function of perspiration, we may note that definite changes take place in many individuals at different periods of life. As a rule, children and young persons sweat more easily than adults, and the latter more than the aged. Many persons who in youth perspired freely, cease to do so when age advances, excepting under very unusual conditions. Now and then, however, this general law is reversed. I think it may be asserted that the liability to sweat easily and profusely, if shown in an adult or aged person, is usually indicative of want of tone.

A Mrs. K—, aged 52, who had suffered from nettlerash, and who was liable to erythematous patches on her hands, complained much of very profuse perspiration. She attributed her eruption to the irritation caused by sweating. She was accustomed every night to wake in a profuse perspiration, which was always followed by extreme coldness of the legs. She was much out of tone, and felt weak and tremulous. Her first attack of urticaria had followed a chill, five or six years ago. She told me that as a girl she had been troubled with a hot, dry skin, and could seldom perspire. Her menstruation had ceased entirely four years before I saw her. I believe that she had lived rather freely as regards beer and spirits.

No. LI.—*Inability to perspire—Ague—Turgid veins over whole body—Subjective coldness.*

Mr. W—, aged 50, from Y—, had never been strong since childhood, and had always been a small eater. He had had rheumatic fever twenty years before; and sixteen or seventeen years before he had had severe intermittent fever. There had been no subsequent attacks. He had always lived in Y—, and had never been specially exposed to malaria. Four years ago he had had sudden swelling of the legs, and he had had also two attacks of vesicating erysipelas on the face. When I saw him his tongue was fissured; and his

venous system over the whole body, legs, arms, and head, was turgid. He complained very much of cold, especially at the back of the neck, and was cased in flannel. His left eye was defective, but the ophthalmoscope revealed nothing. He was liable to unexplained difficulty of breathing; and in hot weather the soles of his feet often became red and tender. He had always been a dry subject; and had ceased to sweat at all lately. He always felt hot and dry. He had taken to riding in the hope that it might make him perspire, but a few drops on his forehead was all that he could ever get. His hands were liable to burn, but he never got them scaly or red like his soles. When he had the ague he "sweated fearfully," and the same occurred on another occasion during an illness. The bowels were generally open; but he was more liable to constipation than to diarrhoea.

No. LII.—*A peculiar form of generalised Ache in the Teeth in association with defective tone.*

There is a very peculiar form of toothache in which all the front teeth ache a little, or rather in which they all feel as if set on edge. It occurs in connection with defective tone, and perhaps as a symptom of gout. It happens sometimes when tea has been taken in excess to get rid of headaches. The liability may last a few days or a week, or more. The ache is in the teeth themselves, not the jaw, and the front teeth only are affected. The ache is not severe; it is more a sort of mild setting on edge than aching. Everything which might tend to set on edge in an ordinary way becomes intolerable, and sometimes the squeaking of a pen in writing cannot be endured. I have known those who could not use quill pens on account of the liability to this kind of toothache, and one or two who for a while were obliged to desist from all writing.

No. LIII.—*Paraplegia from Tuberculous Pachymeningitis—Death in the fourth year.*

Volume X. of the Transactions published by the Royal Academy of Medicine of Ireland contains, as always, some very valuable papers. Amongst those which have especially

interested me are one on a case of Endothelioma of the Lesser Omentum, by Mr. Conolly Norman, and one by Professor Bernard on fractures of the carpal end of the radius. There is also an able and very practical paper by the Editor of the volume, Mr. William Thomson, of the Richmond Hospital, on Enterotomy and Colotomy. Professor Birmingham records a case of unique malformation of the heart, with woodcuts. It may be noted that a condition of cyanosis did not save the patient from a rather rapid attack of pulmonary phthisis. Dr. Bewley describes a case of chronic, tuberculous, spinal pachy-meningitis, which is very valuable on account of its completeness as well as from the great rarity of that form of disease. This case is of such interest that I venture to reproduce it in the space-for-time schedule form.

*Pain in the back, followed by paraplegia, which was complete in six months—Paraplegia permanent—Death at end of fourth year from tubercular meningitis—Tuberculous disease of vertebra and pachy-meningitis of theca—Patient a man aged 41, previously of good health. (Dr. Bewley's Case.)*

DATE.	DETAILS.
1887	April:—began to suffer pain in lower part of back; worse at night. He continued at business. In July, defect of perception in treading and difficulty in walking. Admitted into hospital July 12. Defective sensation and inco-ordination, but no loss of power.
1888	Absolute paraplegia. Reflexes excessive; sudden violent pains darting down legs. Occasional need of catheter, but not often. Lower limbs gradually became acutely bent at all joints. Left the hospital in June.
1889	At his home in the condition above described of absolute paraplegia. No evidence of disease of the vertebræ could ever be found, although carefully sought for.
1890	At home paraplegic and with stiffened limbs. Sensation much impaired. Angular curvature in the lower dorsal region became developed in May. Returned to hospital in November with abscess below clavicle.
1891	Became weaker. Had pyrexia for first time. Died comatose in February.

AUTOPSY.—Tubercular meningitis of brain (acute). Old pachy-meningitis of cord and disease of vertebræ.

The post-mortem showed the spinal canal of good size everywhere. The tenth dorsal vertebra was soft and carious, and around the theca, in the dorsal and lumbar regions, was some soft, putty-like material. The changes of greatest interest were, however, inside the dura mater. From the third cervical downwards the dura was lined by a soft membrane, which became in the lower dorsal region thick and tough. At this part, but not elsewhere, it firmly adhered to the visceral arachnoid and pia, which were themselves much thickened. The membrane was a quarter of an inch thick on the front and sides of cord, and had compressed the latter to half its normal size. In the lumbar region the false membrane gradually thinned off, and at the lowest part of the canal the thecæ were quite healthy. The brain showed acute tuberculous meningitis, which had been the cause of death.

No. LIV.—*Abortive treatment of Syphilis—Success*  
—*Early symptoms of Tabes (?) in eighth year.*

Mr. P—, aged 24, who had previously been under my care for spermatorrhea, consulted me on September 9, 1885, for a well-characterised hard chancre. We began mercurial treatment at once, and he never had any secondary symptoms whatever. The treatment was continued for about six months. He married in 1892, being then in excellent health. In 1893 he came to me on account of pains in the lower limbs, which might possibly be the beginnings of tabes. He said that he had “half-minute pains, coming on in a jump,” in his legs. He complained also that he was liable to become giddy if he danced, and that very small quantities of stimulants made him uncomfortable. There had not at any time been any symptoms indicative of tertiary syphilis. His knee-jump was good, and his pupils fairly active. He had very troublesome constipation. I contented myself with treating the case as one of marital neurasthenia, and gave him the proper cautions. At the same time I could not avoid suspicion that the symptoms complained of might prove more serious. Whilst the predisposing cause of tabes is in my experience syphilis, the exciting one is usually sexual indulgence.

No. LV.—*Paralytic Mydriasis without other ophthalmoplegic symptoms—Subsequent development of Tabes.*

The special symptom of paralytic mydriasis without other implication of the third nerve was present in the following case. A gentleman, now aged 36, had syphilis when 18, and at the age of 33, whilst in good health, found his right pupil dilated. It remained just as it was when first observed up to the time of his consulting me, three years later. No other indications of implication of the third nerve followed, and in the affected eye accommodation was defective but not lost. The other eye remained all but normal, its pupil being at the time I examined it of the usual size and fairly active. He needed a low convex glass for reading, but could manage letters of No. 1 with the right, and read it moderately well with left (without glasses). This mydriasis had proved to be the first symptom of tabes. Within a few months of its occurrence there was numbness of the ulnar border of the left forearm, and not long after this the front of the abdomen became numb and so sensitive to heat and cold, that he could only wash himself with tepid water. Next there came ataxic pains of both kinds, lightning and gnawing, with entire loss of knee-jerks. When I saw him three years from the beginning he could only just manage to walk without help.

No. LVI.—*Bullet lodged in the head and never removed—Hemiplegia—State of patient four years afterwards.*

I had an opportunity last year of examining the condition of a young man who, four years previously, had had a bullet put into his head, and from whom it had never been removed. The bullet was a small one from a toy pistol, which had been fired inadvertently. A depressed scar in the squamous bone was to be still recognised, marking the point of its entrance. It was about an inch above the right ear. The bullet was believed to have passed obliquely forwards. His history of the occurrence was that he fell immediately, but never wholly

lost consciousness. He lost all power in his left arm and leg. He was in bed for about a month, and catheters had to be used. The surgeon who attended him sought for the bullet, but could not find it. By degrees he regained power in the paralysed limbs, but they were still not so strong as the others. He fancied that they had recently become weaker, but I could not make out that he had much reason for believing so. The calf was smaller and softer than the other. He had of late suffered much from neuralgia across both eyes, and had been wanting in general tone. I was inclined, however, to suspect that these symptoms had more to do with his sexual system and nocturnal emissions than the accident. Both his pupils were very large, the right being larger. His vision in both eyes was perfect, and the optic discs normal. He complained that his left limbs felt numb when he was tired.

No. LVII.—*On the form of Neuro-retinitis which occurs in Secondary Syphilis.*

A gentleman who consulted me in February, 1892, afforded some facts of considerable interest in reference to the history of syphilis, more particularly as regards the recovery from neuro-retinitis in the secondary stage. In 1887 he had a chancre, and placed himself under the care of a very able surgeon, who gave specifics, but probably not for long. So far as is known no secondary symptoms occurred. The temporary suppression of the disease was so complete that the diagnosis was assumed to have been in error, and ten months after the chancre the patient was allowed to marry. Within a few months of his marriage, however, he suffered from a severe attack of double neuro-retinitis. This was at once recognised as syphilitic, and treated efficiently by several months of mercury. It was a severe attack, and, according to the patient's memory, he was for some weeks almost blind. He finally recovered with almost perfect sight in his left eye, but with a very large central scotoma in the right, which still renders it quite useless for reading, &c.

The history as regards this patient's married life is briefly that his wife, so far as he knows, never showed any symptoms.



She died of acute phthisis about eight years after marriage. Her first three conceptions had ended in premature dead births, but after these three children were born, who did not appear to suffer, and all of whom are still living.

To return to the patient's own case, I may say that I had an opportunity of examining his eyes five years after the attack of retinitis. In his right eye, which was defective, I found the whole yellow-spot region involved in a blur of greyish white. The patch shaded off gradually into the adjacent retina, and there was no trace of pigmentation. Near to it were several smaller patches of a similar kind. They were wholly different from those resulting from choroidal disorganisation. I did not detect any very definite changes at the margins of the disc, and the retinal vessels were not diminished in size. In the other eye I did not find any conspicuous changes. In his defective eye the patient had good peripheral vision, and, excepting that he could not see to read with it, its condition caused him no inconvenience.

No. LVIII.—*Liability to pain behind the lesser trochanter increased in certain positions of the limb.*

When an intelligent surgeon becomes himself the subject of disease there is almost always something to be learned from his observations. My friend Dr. T—— (æt. 52) is much annoyed by liability to pain just behind the lesser trochanter of his left femur. The pain occurs during walking, and comes and goes, and especially is it always brought on, when in bed, by the attempt to rest on the opposite side. He is always obliged to turn back at once. The affected spot is sometimes tender, but I could detect no swelling. The pain does not pass down the thigh like sciatica, but keeps to one spot. It began, in the first instance, after unwonted exertion in walking in Scotland, and was then so severe that it kept him awake two nights. He is of rheumatic tendencies, but has no manifestations elsewhere. He tells me that since he became liable to this peculiar pain he has met with several other persons who suffer in an exactly similar manner. In all whom he has seen the liability to pain when resting on the sound side was a marked feature.

These localised pains are common in gouty persons, and may occur in various parts. They usually follow some slight injury or unusual exertion. Their peculiarity is, as in the case narrated, that the pain is only elicited in certain special positions. In all other positions the patient is quite free. Not unfrequently there is no tenderness, and unless the limb be placed in the one special position, no pain whatever is produced. They are due, probably, to a local inflammation of ligament or cartilage, or in some instances to a local neuritis.

No. LIX.—*Unilateral Pigmentation.*

Dr. William Ord brought to me a most interesting example of unilateral pigmentation. The condition had been slowly developing during four years on the left pectoral region and side of neck of a girl aged 11. Miss H——, a Jewess, was of fair complexion, but with chestnut-brown hair. She had a remarkably clear and transparent skin. She had not a single freckle on her face; although only 11, she had the growth and appearance of 15. Her left pectoral region was covered with little brown spots, they were limited by a vertical line up the middle of the sternum to the root of the neck, and only very few passed to the right of this line, and none of them to more than a quarter of an inch. From the sternal end of the clavicle, a line drawn to the front of the ear would about mark their boundary on the front of the neck, whilst one passing from the ear down to the front border of the trapezium to the clavicle would limit them posteriorly. They occurred over the whole of the pectoral region to a little below the nipple, and there were two or three very conspicuous scars upon the aureola of the latter. The position and character of the spots will be best estimated by examining the portrait which was taken by Miss Green. There was not a single spot on the back of the neck, nor any on the shoulder or arm. None of the spots were larger than a threepenny-bit, and most of them somewhat less; none of them were exactly rounded. Miss H——'s mother said that the first spots had been observed just over the inner end of the clavicle. She considered that they had been gradually increasing in number and size during the last four years.

No tendency to retrogression had been noticed, and nothing in the nature of scaliness or congestion could be appreciated. The spots stood on an otherwise normal skin.

No. LX.—*Herpes after a long course of Arsenic.*

Mrs. S—— had been for long under my treatment on account of lupus erythematosus. She had taken continuously from June 2, 1892 to January, 1893, a dose containing one drachm of Solution of Bichloride of Mercury and five minims of Pearson's Solution of Arsenic. In January she came to me with a group of herpetic vesicles on her left temple. A curious feature in the case was that she had a good deal of swelling of the whole of the side of the face and possibly some enlargement of the glands in the upper part of the neck.

No. LXI.—*Notes on some rare forms of Herpes.*

The family group of herpetic maladies must be considerably enlarged. We begin by the clear recognition of two forms of herpes—common shingles, which may appear on any part of the cutaneous surface, and is usually not recurrent; and H. labialis, which occurs only near the central orifices of the body, and which in those who have once had it is exceedingly prone to recur. We recognise as essential features in both of these, that they are transitory forms of inflammation of the skin, due in all probability to local neuritis, that they are spontaneously curable, and never attended by the production of self-infective elements. The local characters of the eruption are also distinctive and very valuable means of recognition: thus the group of herpetic vesicles is always more or less panniculate or corymbiform in its arrangement, never round nor showing abrupt margins. Its vesicles are never discrete, but are heaped up one upon the other (like mountains, not like mole-hills).

Accepting the general features which we have just indicated as being characteristic, with various modifications, of all herpetic inflammations, we have, next, to include in the family group a number of other cases which at first sight

might not have been recognised as such. Thus, there are many cases of sore throat, sore tongue, and the like, which in their transitory duration, frequent recurrence, and unilateral asymmetry, are clearly herpetic, although from the nature of the structure involved they never exhibit any definite vesicles. Respecting some of these, especially those so common after syphilis, it is not always the fact that the duration is definitely limited. Next, we have cases in which the herpetic vesicles occur on the skin at a greater or less distance from any of the orifices, and in which, whilst in all external features they exactly resemble those of zoster, this most remarkable difference is observed, that they tend to recur over and over again in exactly the same place. Here we have a sort of connecting link between herpes zoster and herpes labialis.

Another group of aberrant forms of herpetic affections is encountered in certain cases in which an eruption on the skin, which closely resembles herpes zoster in the arrangement and formation of its vesicles, is wholly unlike the latter, being generalised, bi-lateral, and persistent. The belief that these cases, in spite of the dissimilarity just indicated, are really and essentially of a herpetic nature is much assisted by the fact that they are for the most part curable and preventible by the same remedy which cures and prevents herpes, that is, arsenic.

It will be seen that our conception of herpes, which was simple and tolerably definite so long as we knew only of herpes zoster and herpes labialis, has become, with the addition of the other forms referred to, somewhat vague and indistinct. We must, however, go yet further, if we would attain to a clear recognition of all that herpes really is. Zoster and labialis must be allowed to serve only as conspicuous sign-posts to attract our attention and induce further search. That the development of vesicles is an accident of the structure affected, and by no means essential to a herpetic inflammation, must be freely admitted. In most cases even of common zoster, parts of the skin which are affected fail to develop vesicles; and in many cases, over the whole of the involved area, although the characteristic pain and redness

are present, the attack ends abortively, so far as the production of vesicles is concerned. On mucous membranes the production of definite vesicles is rare, or they break so soon that they are not recognised, and probably we have many cases in which redness and pain are the only symptoms. Admitting these facts, it is not too much to ask belief to the creed that we may have inflammations of solid structures or of serous membranes, essentially herpetic in nature, but which are quite unattended by the production of vesicles. A local inflammation of neuritic origin, and not a local dermatitis attended by vesicles, must be our definition of herpes.

It has often been remarked that herpes zoster but rarely passes so low on either extremity as to affect the hand or foot. It is often seen on the upper arm, and sometimes on the fore-arm, similar statements being true as regards the thigh and leg: it very rarely, however, passes the wrist and ankle. When it does so, the cases usually present some peculiarity. I have just seen, in consultation with Dr. Morriston Davies, a very remarkable example of recurrent herpes affecting the hand. The patient, a married lady of 28, had, when she was brought to me, a definite group of herpetic vesicles, clustered together exactly like shingles, along the ulnar side of her index finger. There were others, less well developed, in the palm of her hand, in a line with the index. They had been out a few days. The history was that she had been liable to attacks, always on exactly the same part, at intervals during the last five years. They had persisted in recurrence, and, indeed, the intervals had become shorter and shorter in spite of much treatment both by physicians and specialists. This treatment had, I was assured, included a long continued course of arsenic. Mrs. M—— did not consider that her trouble was in any way connected with her general health, for she was never ill. She had borne three children, and during one of her pregnancies, the last, her eruption continued to recur almost regularly, once a month, during the whole time, and she had an attack within two weeks of her confinement. Her first attack had been five years ago, and was less severe than many of the subsequent ones. During the first two years the intervals

had been three or four months, but latterly much shorter. The eruption was attended by much burning, and usually disabled her hand for a week or ten days. It had, therefore, been a great source of inconvenience to her. She had no other form of skin disease, but on one occasion a group of herpetic vesicles had appeared on one thigh and run their usual course.

I have seen a good many cases of recurrent herpes, and they constitute a very peculiar, and probably, if we could understand them, a very instructive group. I put aside for the present those in which the genitals or the lips are affected, since they are very common, and since they do not closely resemble the type of herpes zoster. The class of cases to which I now allude are those which are indistinguishable from zoster in the form and arrangement of their patches. Examples of this are decidedly infrequent; they occur occasionally in connection with diseases of the nervous system, such as tabes (of this I think Dr. Buzzard had recorded a good example), and under these circumstances usually affect the buttocks or upper parts of the thigh. I have had to treat some very troublesome cases in young patients in whom the disease occurred on the neck or cheek: I do not think that I have ever seen recurrent herpes on the more usual position of zoster, *i.e.* the trunk. On some part of the thighs or buttocks, neighbouring the genitals, or on some part of the face or neck near to the mouth, are its usual sites. As a rule, the tendency to recurrence is definitely controlled by the use of arsenic. The case which I have just recorded above was very exceptional to my experience in this respect. I have under care a young lady who has taken arsenic more or less continuously for the last fifteen years, in order to prevent the recurrence of a very troublesome patch of herpes in the lower part of one cheek. Whilst taking the drug she never suffers: but if she leaves it off for a few months, she is almost certain to get a patch. It is a most definite fact that the recurrence almost invariably occurs on the same part. In the case just described it has always been exactly the same nerve-tract in the hand that has been affected. In others the eruption may not recur on exactly the same part, but is still usually so near to it as to make it evident that it is the same nerve-twig that

is affected. Some of the recurrent cases, more especially of course those in association with tabes, have occurred in patients who had previously suffered from syphilis, but in several there has been no suspicion whatever in this direction. There was none, I believe, in the case which I have recorded above.

No. LXII.—*Case of Morphœa, in which Ivory Patches were arranged in zones, in bilateral symmetry, on shoulders and hips—Symmetry not complete—Much pigment deposit.*

The detailed study of cases of herpes and of morphœa is of much importance in reference to the physiology, and even possibly to the anatomy, of the nervous system. That in a general way the changes of morphœa are distributed through the influence of nerves, much as are those of zoster, is now, I think, generally admitted. There are, however, some apparent exceptions to such a law of distribution, and there are many facts which require painstaking investigation before they can be brought under it. The matter is indeed by no means so simple and easy as it usually is in a case of zoster.

A case, illustrating a very remarkable and exceptional arrangement of morphœa patches, has just been under my observation. The patient was a married woman, aged about 54, in whom the disease had commenced about six months before I saw her. It began, she said, in October, 1892, by a little irritation on the lower part of her back, and almost at the same time she noticed that there were some patches of discoloration on her neck. She knew of no cause for it, and had usually enjoyed good health. About Christmas her skin was so irritable that it made her feel somewhat ill. There had been, in the first instance, a little dry exfoliation. The feature that first attracted attention when I saw her was a diffusé, brown discoloration of the lower part of her neck and upper part of her chest. It was soon noticed, however, that with this there were many streaks or dots of the lardaceous stage of morphœa. These were chiefly conspicuous about the clavicles. On the left forearm, a little below the elbow, there

was a small, oval, ivory patch. With this exception, the upper extremities were free. When she had undressed, I found that a zone of discoloration, upon which indistinct white patches occurred, occupied her hips, buttocks, and upper parts of thighs. Below this, on the fronts of the thighs almost to the knees, there were a number of oval, ivory patches very well characterised. A single small patch of the same kind occurred in front of the left leg. The skin on the whole of the discoloured zones was stiff and rigid; quite different from that of the unaffected parts. Between the diseased zone involving her shoulders and that involving her hips, the skin of the lower part of chest and upper part of abdomen was perfectly healthy. So also was that of her head and face, and, with the exception referred to, of her upper extremities. She was a thin, pale, nervous woman, but her hands did not show the slightest tendency to sclerodermia or to Raynaud's phenomena. Her circulation was indeed good.

It will be seen that we have, in this case as in others, good reason to believe that the changes in the skin were located by the nervous system; for it is not possible in any other way to explain their very peculiar arrangement, nor is it, as I have observed in several other cases, an unrecognised occurrence for the changes of morphœa to be grouped in fair bilateral symmetry. I do not, however, recollect to have ever seen a case in which the changes occurred in definite zones, as in this instance. It will be seen that the chief exception to bilateral symmetry was in the development of a patch on the left forearm and left leg, which had no representatives on the other side. The occurrence of deep, diffuse pigmentation of the integument near to the lardaceous patches was also much in excess of anything that I have seen in similar cases.

#### No. LXIII.—*Two Cases of Sclerodermia.*

Dr. Stephen Mackenzie brought to the Dermatological Society on February 9, 1898, two most interesting cases, illustrating the two forms of sclerodermia. Both patients were children.



The first of these, a boy of about 14, afforded an excellent example of what used to be known as "the hide-bound condition." His skin everywhere was stiff, and slightly indurated. This condition was, as usual, most marked on the extremities. Then his fingers were tapered, very pale, and hard as wood: passing up the fore-arms the condition gradually diminished, but did not wholly disappear. The skin of his face was tight, and his features fixed: he said that he could not laugh; he could, however, shut his eyes and his mouth, the degree of induration being only slight. On the trunk the skin, although still slightly stiff, was much less affected; that of the scrotum and penis was absolutely free from even the slightest degree of induration. It contrasted markedly with that of the adjacent parts of the abdomen. The skin everywhere was very white. There was no actual cedema, but it still looked and felt as if it were in a slight degree swollen. The boy looked ill, and his abdomen was tumid. The account which he gave of his malady was that it had come on rather gradually at a time when he was in his usual health, about six months ago. He had previously had an attack of typhoid fever, but he thought that he had well recovered from it some months before any change was observed in his skin. He had just been apprenticed to a wood-carver; he had found the work too much for him, but he assured us that it did not involve any exposure to cold. Before this illness he had not been liable in any special degree to coldness of the extremities, and had been accustomed to mix with other boys on equal terms. Dr. Mackenzie told us that conditions resembling those of Raynaud's phenomena had frequently been observed in his hands and feet, but there had been as yet no approach to gangrenous states. The conditions in this lad were both symmetrical and universal (with the exception of the genitals); the hide-bound condition differed only in degree in different parts, and these differences of degree corresponded exactly in the two halves of the body.

Dr. Mackenzie's second case was one which some observers had regarded as, like the preceding, an example of diffuse sclerodermia. From this opinion, however, I was obliged to differ. The case appeared to me an example of localised

morphea with an exceptional tendency to bi-lateral symmetry, which, although deceptive at first sight, ought not to be allowed to disturb the diagnosis. The conditions, although severe and extensive, were far from being diffuse and universal, nor was the symmetry exact. It was a case in which the limbs were chiefly affected, the head, face, and neck having escaped. There were numerous and characteristic ivory patches on both extremities, and one, which was small but very definite, on the left side of the abdomen, midway between the umbilicus and pubes. Both hands were bent forwards at the wrist, and there were patches, which appeared to be partially scars, on the backs of both wrists. The skin on the front of both knees was also somewhat excoriated. Over the greater part of all four extremities the skin was tight and indurated, but this was not quite universal, even on those parts, and although very extensive, the changes were arranged more or less in patches and streaks. In marked difference from what occurs in diffuse sclerodermia, the digits themselves, both of hands and feet, had almost wholly escaped, and their skin was supple and soft. The skin also of the girl's face and neck showed no change whatever, and could be easily pinched up into large folds. The same statement is true, with the exception of a few small patches, of the skin of the entire trunk. The duration of the disease in this case was, I believe, about a year. It appeared not at all unlikely that the lower limbs might be disabled permanently. The hands were in a more hopeful state, although somewhat crippled.

COMMENTS.—Although it may be admitted that there are still gaps in our knowledge as to the relationships of the two, yet it may be safely held that the two types of sclerodermia differ essentially. One is always and accurately symmetrical and always affects the hands and face; the other, although it may be bilateral, is very rarely indeed accurately symmetrical, and avoids rather than otherwise the parts named. The one often appears to have some alliance with Raynaud's phenomena, the other has none whatever. In Dr. Mackenzie's two cases we appear to have a good example of each. I have already published many exceptional cases, and shall return to the subject at a future time.

## SYPHILIS.

### No. LV.—*Small-pox and Syphilis.*

During the present wide-spread, though not severe, prevalence of small-pox, it is very desirable that the attention of medical men should be alive to the fact that syphilitic eruptions not very infrequently resemble variola in a most deceptive manner. I have published in past years several cases illustrating this fact, some of them very noteworthy ones. I have repeatedly known the subjects of an acute syphilitic eruption either isolated in their own homes, or sent into small-pox hospitals, under a mistake as to diagnosis. In one of these I felt it my duty to record the fact that I had myself in the first instance been deceived and given an opinion which proved to be an error. The fact is that the syphilitic eruption that resembles variola resembles it so closely, and is often attended at its outset with so much fever, that there is little except the history of the case on which to base the diagnosis. If, therefore, the history be concealed and the primary phenomena have disappeared, it may be often extremely difficult in the first instance to form a correct opinion. As the case advances, and when the eruption is found to persist or to come out in successive crops, the suspicions of the surgeon will generally be aroused. As a matter of fact, even in the early stage, it is but seldom that the observer will be in doubt if once his attention has been directed to the possibility of syphilis. It is chiefly in the cases in which no suspicion is ever felt as to the disease being other than variola that mistakes occur.

During the last few months two cases have come under my observation, presenting difficulties in the direction above referred to. In the first, a gentleman, whom I had myself

treated for syphilis fifteen years ago, came to me with a general eruption which had been out only four days. He assured me that he had been exposed to no fresh contagion, and requested me to examine his penis. I felt sure that such an eruption as he had could not possibly have anything to do with his long-distant syphilis, of which indeed he appeared to be perfectly cured; and when I learnt that, prior to the appearance of the spots, he had been for two days under his family medical attendant with backache, sleepiness, and general discomfort, I felt sure that we had to deal with a case of modified variola. This diagnosis was subsequently confirmed by others, and although the patient felt well, had normal temperatures, and was very anxious to proceed on a journey to Scotland, we insisted on his isolation. He had been twice successfully vaccinated, and hence probably the mildness of his attack. As regards the eruption, the diagnosis lay between varicella, variola, and syphilis. The latter being excluded, the induration of the pustules at their base, and the fact that there had been distinct premonitory febrile symptoms, made me feel certain that we had to deal with small-pox, and not with varicella.

The following are the particulars of my second case:—

When Mr. T—— came into my room, noticing that his face was covered with scars and stains, I asked, “Have you had small-pox or syphilis?” His reply was, “Both.” He at once explained that his syphilis was two years and a half ago, but that he had only just left a hospital in India, where he had been treated for an attack of small-pox. On making him strip, I found that he was covered not only with scars which looked like those of variola, but that he had a number of little shotty tubercles which looked much like variola spots in course of development. Many of these were obviously recent, and he told me that they were still coming out. On asking for exact dates, I found that he had been cured of what he called his attack of syphilis, and which had in all probability been such, by a few months’ treatment; and that he had subsequently enjoyed two years of excellent health and entire immunity from symptoms. Then, on February 13th of the present year, he went to a Calcutta hospital to be operated

upon for a fissure of the rectum, being at the time in excellent health and without a spot on the body. Ten days after his admission to the hospital an eruption began to appear, and he had evening temperatures from  $101^{\circ}$  to  $103^{\circ}$ . He was confined to his bed, and the eruption was diagnosed as small-pox. Very shortly afterwards ulcers appeared in his tonsils, which required the application of caustic. He was told that he had both diseases together, and that the effect of the small-pox had been to bring into activity his long latent taint of syphilis. On the 10th of March, whilst his small-pox eruption was fully out, vaccination was done on both arms, and two vesicles on each arm rose, as he said, splendidly. Of these large, thickened, and congested scars still remained at the time of his visit to me. In the beginning of April—that is, about a month after the outbreak of small-pox—mercury was ordered, and from this date improvement was steady. When Mr. T—— called on me on May 20th, exactly three months had elapsed since the beginning of his eruption, but he still had grey-edged ulcers in his tonsils, and, as I have already said, his body and limbs were covered with small scars like those of small-pox, and with shotty pustules, which might be either developing small-pox or syphilitic tubercles.

I could make no doubt that he was the subject of a recent attack of syphilis, and having regard to the fact that the vaccination had taken well, whilst he was covered with the eruption which was called small-pox, I thought it probable in the highest degree that he had never had the latter malady at all. A suspicion crossed my mind that such was probably the opinion of his former medical advisers, although they had not told him. It seemed very improbable that they would have vaccinated him unless doubt had been felt as to the diagnosis of variola. Since it was obvious that such an eruption attended by symmetrical sore throat could not possibly be the result of syphilis, which had been apparently cured two years ago, I next directed my attention to the search for a new chancre. It occurred to me as possible that the sore which he had in the anus might have been a chancre, but, on examining his penis and groins, it seemed scarcely necessary to entertain that hypothesis. He freely admitted

that he had been occasionally exposed to risk, and that he was very liable to have abrasions. Although there were no definite remains of a chancre, there were suspicious appearances, and the glands in both groins were hard. Thus I have no hesitation in believing that we have to do with a case in which a second infection of syphilis was attended with a variola-like eruption and high fever. Although there was small-pox in the hospital into which the man was admitted, and a child had there recently died of it, yet he was not aware that he had been exposed to contagion; and the subsequent successful vaccination appears to show conclusively that he had at any rate not taken any.

#### No. LVI.—*Narrative of a Syphilitic family.*

Cases, in which several brothers and sisters suffer from inherited syphilis, afford us some of the best opportunities for the study of the laws under which such transmission takes place.

I treated, about five years ago, a married lady for a large glandular abscess in the neck, which I at first thought to be only of a strumous nature. Whilst I was attending her she brought to me her eldest child, a girl of about ten, with phagedænic ulceration of the palate and fauces. I was sure that this could be nothing else but inherited syphilis, and at once altered my treatment for the mother from tonics to specifics. The result was most remarkable, and some very extensive ulcerations in the neck were soon soundly healed. During the last year this lady has been under my care for an acute periosteal node under her left eyebrow. Its suppurated and bare bone is, at the present time, exposed. There can, therefore, be not the slightest doubt that the mother is the subject of tertiary syphilis. The child who had the phagedænic throat, is, as I have said, her firstborn. She is now fifteen years of age, and apparently in excellent health. Her throat, after persevering treatment, healed, though not until there had been very considerable destruction of the parts.

About two years after I had treated the child mentioned, a sister seven years her junior was brought to me with interstitial keratitis and deafness. Her eyes recovered as usual, but she remains, I am sorry to say, almost absolutely deaf. On the day on which I write this (May 9, 1893), a third child in the same family has been brought to me, having suffered from a most severe attack of interstitial keratitis, which has left dense white opacities in the middle of the corneæ, which threaten to be, in some degree I fear, permanent. This youths completes the family, for there are but three, and it will be seen that all have suffered from severe forms of the late manifestation of the taint. There is seven years difference in the ages between the eldest and youngest, and it is thus certain that a mother may remain capable of transmitting the disease to her offspring during the whole of that period; nor can any difference in the degree of severity with which these three children have suffered, be traced. The eldest has had a phagedænic throat, but no affection of either eyes or ears. The youngest has lost her hearing, and has also passed through an attack of keratitis. The middle one, the boy, has suffered from keratitis only.

The narrative which I have just given refers to the same family, the particulars of which are recorded at page 292 of ARCHIVES, Vol. II. My chief reason for again recapitulating the facts is that I may complete them by the addition of the narrative of the boy's case, respecting whom I formerly wrote that he had remained, from infancy upwards, wholly without symptoms. As has been said, he has now passed through a most severe attack of keratitis. I may still corroborate what I formerly wrote as to his not presenting any obvious signs of taint. Unless he had developed keratitis, there is nothing whatever to betray his malady. He is a tall, well-grown lad, and his physiognomy, although peculiar, presents nothing suggestive of syphilis. His nose is not in the least sunken, and his teeth are not definitely notched. His upper central incisors are, it must be admitted, peculiar, but they would certainly not in themselves justify a diagnosis. They slant towards each other, and their edges are a little narrowed by rounding off of their angles. As recorded in my former note,

not one of these three children presented any symptoms in infancy, and, so far as I know, neither of their parents in the least suspect the malady from which they suffer. Thus we have most convincing proof that the taint of inherited syphilis may remain latent until near the period of puberty, for the same occurred in all three children. I have not seen the youngest child since her permanent incisors were cut, but neither the eldest nor the second have definitely notched teeth. The absence of peculiarities of teeth and physiognomy, together with the absence of all history of infantile symptoms, corroborates the hypothesis, which I have always maintained, that such peculiarities are the direct results of inflammations in infancy, and must not be expected to be present unless such have occurred.

At the time of my former mention of this family I had not seen the father himself. I have recently done so, and may now say that he appears to be in good health, and that both he and his wife aver that he has had no ailments since marriage. Considering how severely his three children have all suffered, I did not feel myself justified in asking him any questions which might lead to his recognising the cause of their maladies. I am, therefore, not in a position to state the date at which his disease was contracted, or what happened to his wife immediately after their marriage. I must again, as I have done before, ask my reader's attention to the fact that any one of these three cases might be easily, if taken alone, have seemed to afford very strong evidence on the negative side in reference to the connection of the disease displayed with inherited syphilis. Thus, in the case of the phagedænic throat, it might have been alleged that both parents were healthy, and that the brother and sister were wholly without symptoms and well grown. At one period these statements would have been perfectly true, and, since the patient herself was well developed and showed no signs of taint, it might have been plausibly argued that the ulceration of the throat was merely due to scrofula or some other cause. So again, supposing that if, at the time the youngest child came under care for interstitial keratitis, nothing had been known as to her sister and mother, it might have been



urged that there was nothing whatever to justify the diagnosis of syphilis.

Many cases have been placed on record as being exceptional to the statement that well-characterised interstitial keratitis is always specific, in which the evidence, or rather the absence of evidence, is precisely of the kind here hinted at. Let me repeat that not one of the three children had had infantile symptoms, and not one showed, either in teeth or physiognomy, anything that in the least approached the characteristic peculiarity. Yet, when we regard the evidence afforded by the four cases taken together, no one can for a moment doubt that the mother's glandular ulceration, the eldest child's phagedænic throat, the keratitis in the second child, and the keratitis and ear disease in the third, were one and all definitely syphilitic.

NO. LVII.—*Inherited Syphilis severe in infancy, but leaving no traces—Periostitis and Keratitis at puberty—Mother of the patient in excellent health throughout.*

The following notes were handed to me, as introductory to a consultation, by the mother of the patient, and as they state the facts very clearly, I may as well give them in her own words.

"Five weeks after his birth (1881) our doctor declared him to be suffering from syphilis; skin between thighs being deep copper-coloured red; corners of eyes and mouth split, skin on body coming off in strips; snuffles; constant screaming and crying.

"Treated with iodide potassium (ointment and medicine). At six months old was quite cured, and kept well till he was nearly ten years old.

"In April, 1891, had periostitis. Was treated by our own doctor for nearly two years with iodide potassium (ointment and pills), sometimes varied with iodide lotion; all with little or no effect, the pains at times being most acute at night, and aching at all times upon the slightest exertion. Was wheeled about in a long perambulator, and at other times went on crutches.

"January of this year his eyes also became bad; so in despair I took him to an ophthalmic hospital. They examined his legs as well as his

eyes, and gave him "grey powders." In less than a fortnight the swelling of his legs had gone down a good deal, and all pain and tenderness had completely gone. He can now run and play about with ease.

"He was then treated with mercurial ointment and iron and quinine pills for three months, and has now been told no more can be done for his eyes.

"He is the eldest child."

The boy to whom the notes refer was eleven years of age when brought to me. He was a healthy-looking lad, and there was nothing in his physiognomy or teeth which would have enabled me to recognise inherited syphilis. He had, however, in both eyes evidences of bygone keratitis; and, on the fronts of both tibiae, there were long and very definite nodes. His teeth did not even show in any marked manner the changes peculiar to mercurial stomatitis, and it is interesting to note in this connection that the mother's account stated that he had been treated in infancy by iodide of potassium only. The case is certainly a good example of recovery, without any apparent damage to tissues, from severe infantile symptoms; at the same time it must be remembered that he has not escaped severe periostitis and keratitis. The ophthalmoscope revealed a few small patches of pigment in the periphery of his choroids.

It is of interest to turn to other facts in the history of this family. I did not see the father, but the mother, who had been made acquainted with all the facts, was herself apparently in the enjoyment of most perfect health. She was florid, cheerful, and looked much younger than her years. She said that she had never suffered the slightest illness since her marriage. Her husband, on the contrary, had always been ailing, and was at present suffering from syphilitic ulcerations. There had been no miscarriages, nor had any of their children died. Our patient was their firstborn; the next, three years younger, and now aged eight, had never shown any symptoms. After his birth, for some years, the husband and wife lived apart; but during the last year another child had been born, now aged seven months, who was in perfect health. All three children were boys.

The evidence afforded by this narrative is clearly in favour

of the belief that a father may transmit syphilis without infecting his wife; and secondly, that he may himself continue to be the subject of tertiary symptoms, and yet have untainted children born to him.

No. LVIII.—*Eruption on the Tongue of peculiar character nearly three years after Syphilis.*

Mr. C. M. T——, a tall, rather pale man, who lives freely.

November, 1890.—A chancre with double bubo which did not break; eruption and sore throat cured by a two months' course of mercury under Dr. Fair.

1891-92.—Quite well.

March 24, 1893.—A most peculiar eruption on the tongue. There are scattered white specks, or dots, on the front half of the tongue.

The eruption consisted of a number of white dots, twenty or more, scattered with tolerable symmetry over the front half of his tongue, which was partially denuded of fur. They were slightly elevated, and distinctly rough to the touch. They were of the nature of the filmy patch, but were very small—mere dots, and not patches. They had been developed, he said, within the last four months, and, coincidently with them, some scaly small rings had formed on his scrotum. The latter condition made me feel sure that the disease was syphilitic. It will be seen that there had been an interval of about two years since his treatment. I prescribed the solution of the bichloride of mercury in doses of a drachm and a half. This was on March 24th. He came to me again on April 11th, with his tongue so well cured that it was only with great difficulty that I could find the sites where some of the spots had been. All the appearances depicted in Mr. Burgess's drawing on March 24th had disappeared, and any one seeing the tongue for the first time would have taken it for a perfectly normal one.

No. LIX.—*Pigmented Scars after Chancres in a patient of fair complexion.*

A gentleman of remarkably light complexion (Mr. W——), fair to a degree, is just well of two hard chancres side by side

in the outer skin of the penis. The remarkable point is that the scars which are left are almost black with pigmentum. It is deepest in the centre, not at the edges as is usual in the scars left by ulcers. In this instance there were no ulcers, only long-persisting induration, thus the scar is not where the skin has been destroyed.

I mention this case because in previous writings I have said that pigmented scars occur usually in dark-complexioned persons. It is perhaps noteworthy that Mr. W——'s father is very dark.

No. LX.—*Acquired Syphilis in a man who had suffered from the inherited form.*

An example of syphilis acquired by a person who was himself the subject of inherited taint, occurred in the person of a surgeon, aged 32, who consulted me on February 14th. This patient told me that his father, who was also a surgeon, had told him that he had suffered from inherited taint in infancy. There was also a history of interstitial keratitis, and it was added that a younger brother had also suffered from the latter, and that this brother showed characteristic teeth. A defect in the evidence was that the patient himself did not show characteristic teeth, nor was there anything in his physiognomy or state of eyes which would have induced me to recognise the inheritance which he asserted. He was the third born in the family, and several had died.

This patient suffered severely from his acquired disease. He had contracted the chancre in September, and I saw him in February, when it was still indurated in a very marked degree, and threatening phagedæna. He was covered by a syphilitic eruption.

No. LXI.—*History of children born to parents both of whom had suffered from Syphilis.*

A surgeon was under my treatment in December, 1878, for a chancre on his finger. He got quite well, and I saw nothing more of him until 1892. I had then an opportunity of inquiring as to his family. I found that his wife had contracted

syphilis from him, having been infected before the diagnosis was made. She had borne him two children, both of whom had lived, and neither of whom had shown any symptoms in infancy. The elder of these had remained entirely without symptoms up to the present time, and is now aged 9. It will be seen that he would be born within about four years of the disease in his parents. The younger child, a girl, now aged 8, although through her whole life free from symptoms, has, I am told, characteristic teeth. As I have not had myself an opportunity of examining them, I quite hope that this is a mistake, for I have often been assured that teeth were characteristic which I did not myself consider so. It should be stated that two children have been born since the two mentioned, and that they have never shown a single symptom.

No. LXII. — *Palmar Psoriasis in connection with inherited Syphilis.*

Amongst the cases which Dr. Abraham was good enough to provide for my lecture at the Hospital for Skin Diseases, on Tuesday, May 16, 1898, was that of a girl of eighteen with chronic palmar psoriasis. The patches on her arms were numerous, abruptly margined, and quite dry. For the most part the condition was one simply of peeling, there being little or no accumulation of epidermis. Psoriasis palmaris at this age is of course very infrequent. The girl stated that it had caused her so much inconvenience that she had been obliged to leave her situation as household servant. She was of somewhat stunted growth, and the skin of her face attracted my attention as being peculiarly pale and soft. It was of that silky softness often observed in the subjects of inherited syphilis. Her physiognomy was by no means characteristic of hereditary taint, but it was sufficiently peculiar to induce me to examine her teeth, and we at once found that they were most extensively malformed, and quite typical both of syphilis and of mercurial.

Her upper central incisors were dwarfed and notched, and very defective in enamel. The lower incisors and canines

were small round pegs. The pre-molars were perfect both in form and enamel, and the first permanent molar was in every instance destroyed by caries down to the gum. We next noticed that at the corners of the mouth there were some little scars, that her frontal eminences were more prominent than natural, and that her tongue was extensively bald, and presented some thin, whitish patches. She had had many attacks of inflammation and irritability of her eyes, and was wearing protectives. Thus the diagnosis seemed conclusively established. We were able to carry it a little further, for on sending for her mother, who was waiting, we found that she also had palmar psoriasis and superficial sclerosis of her tongue, and she gave us the history that her daughter, who was her firstborn and the only one that had lived, had in infancy suffered very severely from eruptions, snuffles, and "thrush."

Thus we appear in this case to have a definite example of the so-called psoriasis palmaris, or persisting peeling patches in the palms, in direct dependence on inherited taint of syphilis. I have seen exceedingly few such cases. In asserting that the local disease was due to the taint, it by no means follows that we ought to expect it to prove curable by specifics. Probably the constitutional element consisted rather in a vulnerability of the parts, which rendered them unable to bear the irritation of household occupations, rather than on any direct tendency to inflame when at rest. The same may probably be asserted as to the tongue. The conditions were in both atrophic or desquamative, and were not attended by any thickening. I should therefore regard exemption from local irritation as of far more consequence than the use of mercury, and should much doubt indeed whether the latter would prove of material benefit. Precisely the same reason applies, however, to most of the cases called psoriasis palmaris in connection with acquired syphilis. It is seldom seen excepting in those whose hands have been more or less irritated by pressure.

No. LXIII.—*Second attack of Syphilis.*

*Indurated chancre. Complete success of suppression-treatment continued for eighteen months. Sore throat the only constitutional symptom. Good health during four years. A second indurated chancre in fifth year. Sloughing ulceration of Tonsils.*

AGE.	DATE.	DETAILS.
26	1887	On December 19th he consulted me for an inflamed and well-indurated chancre, involving the corona and adjacent roll of prepuce. It was five weeks since exposure. Mercury ordered.
27	1888	The sore healed in a month. Hard glands in groins. Excepting a doubtful sore throat no secondary symptoms occurred. He continued mercury through the whole year (two grains of grey powder three times a day).
28	1889	Is quite well.
29	1890	Quite well. No reminders of any kind.
30	1891	Quite well. No reminders.
31	1892	Came August 29th with an indurated sore ("a hard disc not ulcerated") of six weeks' duration. Mercury prescribed. October 19th, Sloughing ulceration of tonsils.

The sore for which Mr. S—— came on the second occasion was not in the site of the first one, but on the opposite side. I saw both the sores myself, and on each occasion the induration was most characteristic, as well as the state of the glands. The case affords a good example of the success of the suppression plan of treatment. My belief is, that on each occasion the sore throat was specific, but on both it yielded quickly to the treatment. On each occasion the gland mass was at first unusually large, but on neither did suppuration occur. He was liable to sore throats in boyhood, and had had his tonsils excised.

## GOUT AND RHEUMATISM.

No. XXVIII.—*An instance of Severe Gout with tophi in a woman—Note as to the state of the teeth in Gout.*

It is not very common in English practice to see gouty concretions in women. A lady of 67, who was florid and in excellent health, consulted me on account of an erythematous form of dermatitis approaching eczema. It occurred on her knees and face, and more or less on all parts of her body. She herself attributed it to a shock which she had received from the sudden death of her husband about two years ago. It had not been continuous since that time, but it showed itself very shortly after the shock, and had been recurrent ever since.

There were some interesting facts in this lady's history. She was of gouty family, and had herself suffered from repeated attacks of gout. On her hands and feet there were large chalky concretions, which were quite quiet and painless. She told me that her father was a brewer, and that in her girlhood he had always insisted upon her taking beer. She had drunk beer all her life until the age of 53, when, in consequence of her repeated attacks of gout, she had been advised to substitute whisky. In girlhood she had been very liable to herpes on her lips. About the age of 19 she remembered having a severe illness, which was called inflammation of the kidneys. With that exception she had enjoyed good health through life, and, at the age of 47, she had been successfully operated on for an ovarian tumour by Sir Spencer Wells. Her gout had of recent years been quite in abeyance, and it is to be observed respecting the eczematous condition



of the skin, to which she had become liable, that it did not begin until many years after she had given up taking malt liquor and had been free from gouty attacks. During what we may call her gout-period she had no eczema; and she began to suffer just at the age at which many other persons, not in the least gouty, become liable to dermatitis.

I have just another fact to add. Well preserved teeth are, I believe, not uncommon in families in which gout prevails, but it is not often that we see such a set as this lady presented. She had not lost a single tooth, and she said that she had only once in her life known what toothache was. She had four daughters, who had all been brought up to drink claret, and none of them showed any gouty symptoms.

No. XXIX.—*Gout and Relapsing Eye Inflammations*  
—*Importance of change of climate as a measure*  
*of treatment.*

Miss Q——, a lady of forty-eight, came under my care on account of very chronic disease of her eyes, which had reduced her to almost total blindness. Her left eye was quite blind, and had been so for long; with the right she could see only  $\frac{21}{100}$ . Her history was as follows. Her maternal grandfather and one of his sons, her uncle, had suffered very severely from gout. She had herself been a delicate child, and very liable to chilblains. She had never been kept in bed by rheumatism, but had often suffered much from rheumatic pains and had had sciatica. She had also been troubled with piles. She had been accustomed through most of her life to take beer or stout to lunch and dinner. The disease of her eyes had been threatened at the age of twelve; but on that occasion she wholly recovered, and remained quite well until she was twenty-two. At the latter age she became liable to attacks in the right eye, probably of the nature of cyclitis. For several years her left eye, as far as she could remember, remained free. Afterwards she became liable to recurring attacks, first in one and then in the other, and during the last few years she had rarely been

free for more than a month or two at a time. She had been under the care of a very able specialist, by whom repeated iridectomies had been performed in the hope of arresting the disease. Sir William Bowman had dissuaded her from any attempts at cure by operation. When I was consulted, the left eye was in such a condition that I advised its excision. The whole cornea was leaden, and bulging with dense white opacities here and there. In the right eye there were large opacities in the vitreous, iritic adhesions, and marginal opacities in the cornea. The disc could still be seen, and I could not detect any choroidal mischief. The tension of the eyes was slightly —.

I place this case on record as a good example of the final result of relapsing inflammation of the eyeball in connection with inherited gout. These inflammations may vary somewhat in their character in different cases, but their especial feature is a tendency to relapse and finally destroy the organ. The iris, the ciliary region, and the cornea are usually all involved together, and the early formation of opacities in the vitreous is a very common event. So far as my experience has gone there is but one method of treatment which ought to be trusted, and that is a complete and prolonged change of climate. The performance of iridectomy, although to a certain extent beneficial when there is tendency to closure of the pupil, is but a very uncertain remedy. It does not prevent relapses, and although, as in the present case, it may be repeated several times, the final result is usually disappointing. Nor is the use of tonics or of mercury or iodides more satisfactory. On the other hand, I have never known a case in which complete change of climate, and especially residence in a semi-tropical country, did not arrest the disease. Several of my patients have gone abroad for permanent residence, but in a few very definite examples a year's residence abroad has appeared to be sufficient, and no relapse has occurred on return to England. I have recently been made acquainted with the result in a case of this latter class, which at one time caused me much anxiety. The patient was a young married lady who had several relatives in the medical profession. She had a strong inheritance of gout.

and had become liable to recurring attacks of iritis. My recommendation that she should go to South Africa or some similar place for a full year was strongly opposed, on the ground that liability to such attacks as she suffered from made it necessary that she should remain within reach of good specialist advice. I insisted that change of climate would be her only remedy, and succeeded in prevailing upon her husband to take her abroad. She returned from an eighteen months' travel in South Africa, Australia, and New Zealand in strong health, and with her eyes perfectly well. It is now six years since she came home, and I was told not long ago by one of her relatives that she has remained without relapse. Had she not tried the radical measure of change of climate, I have little doubt that her case would have run the same course as the one which I related before illustrates.

No. XXX.—*Severe Osteo-Arthritis in a Boy—  
Remarkable distortion of joints, &c. (with portrait).*

The illustration which I have here given is a copy of one published by Mr. Thomas Brayne, of Banbury, in the Transactions of the British Medical Association in 1834 (p. 366). The subject of the case was a boy aged seven, born of healthy parents, and the sixth of eight children. The other children were fairly healthy, but more or less strumous. In the case of the patient some symptoms of stiffness about the right elbow were observed during the first month or two of infancy. After that the child suffered continuously from diarrhoea, with emaciation of his body and limbs and enlargement of most of his joints. The diarrhoea continued, in spite of much treatment, during two years, and then gradually abated. There was very troublesome prolapse of the rectum, and the fæces were intolerably foetid. No tumidity of the abdomen was observed until he was three years old.

At the time the sketch was taken the child, aged seven, is described as having a sallow aspect and rather vacant expression, though he had good mental powers. His skin was dry, and on his forehead, neck, and shoulders were "spots like

the psoriasis guttata of Willan." His voice was squeaking, as though uttered through a reed; but there was no enlargement about the throat, either of the larynx or the thyroid glands. The shoulders were high and the sternum prominent. He could not materially alter the position in which he is represented, and his back was stiff and curved, and his knees and elbows "ankylosed." The anterior fontanelle was not quite closed. The cranium measured in circumference round the temples twenty inches. None of the long bones were in the least curved. As regards the enlargement of the joints, it would appear to have been supposed by the describer to be chiefly due to the overgrowth of epiphyses. On this point I must give the exact words of the writer: "The bones of the pelvis, and upper extremities of the thigh bones, present nothing unusual; the latter have the natural degree of curve in their bodies, but, in the view taken, the thighs are entirely concealed by the enlarged knees. The right knee measures one foot seven inches in its greatest circumference, and is as large as the head within one inch. The relative proportion of the articular end of each bone which enters into the composition of the joint, as well as the situation of the patella, can be discovered by careful examination, and they all seem enlarged in nearly the same degree. The surface feels hard and unyielding, and large veins ramify over it, adding to the dark red colour which the skin has acquired from long distension. The integuments of the intestines between the bones are very slightly œdematous. The left knee measures only one foot three inches in circumference. The elbow, wrist, and ankle joints are also greatly enlarged, as the figure represents. The elbows are also so much ankylosed that all flexion and extension are destroyed, so much so that he can only reach his lips with the ends of the fingers of the left hand, and this with the greatest difficulty. The hands are only the size of those of a child of two years old, and the fingers are clumsy and ill-formed."

This remarkable case may, I think, be suitably allowed to stand as a type form of a certain group, in which severe epiphysial disease occurs in young children. It may possibly be in some degree allied to rickets; but at the same

time it is quite possible that it is nearer to chronic rheumatism or osteo-arthritis. We need to have our terms carefully defined before we engage in any controversy as to the appropriateness of one or other of these names. What is proved is that a child became the subject, in early infancy, of a widely spread affection of the epiphyses of the long bones, which resulted in great permanent enlargement of them, and so much stiffening of joints that it was called ankylosis. There was no bending of any of the long bones, and, although in connection with this it is to be remembered that the child had probably never made much effort at walking, yet we have the corroborative fact (against the idea of rickets) that the chest showed no special degree of malformation. The child was the sixth of a family of eight, and was suckled by a mother who had successfully nursed the others. It seems tolerably clear that the disease was an affection of epiphyses, inflammatory in character, and leading to overgrowth, rather than a generalised defect of the bone formation process, which is our central conception of what is meant by rickets. Just as chronic rheumatism or osteo-arthritis does in the adult, we find that it exempted certain joints, whilst others suffered very severely. Thus the hips and the shoulders escaped, whilst the elbows, wrists, knees, and ankles were all involved. It may have been that the small joints of the hands suffered, for it is stated that the fingers were clumsy and ill-formed. Taking all the facts together, it appears to me more likely that the disease was, as regards its cause—which, I submit, is the only safe basis for diagnosis—much more nearly allied to chronic rheumatism than to rickets. It may have been that the two were mixed together, for probably but few infants, suffering through long periods from any cause of exhaustion, such as, in this instance, profuse diarrhoea, wholly escape some tendency to the rickety state of nutrition. The occasional association of diarrhoea with rheumatic tendencies is well known, as has been the subject of record especially in connection with prisons. Any exhausting disease, indeed, such as diarrhoea or repeated and profuse losses of blood, menorrhagia, and the like, may become the foundation, in those hereditarily predisposed, of chronic rheumatic arthritis.





Anything of the nature of the latter malady is, of course, rare in infancy; but it is by no means unknown, and we may readily recognise the probability that in young and rapidly growing bones it might produce extraordinary malformations.

No. XXXI.—*Suppuration in Gouty Arthritis.*

It is fifteen years since I attended Mrs. C—— for acute gout of the right ankle, which suppurated. I had to open the joint, and under treatment by spirit lotions it healed without ankylosis. It was put up in plaster of Paris. It was a year or more before she could walk on it. She went about on crutches for long.

During the last twelve years she has walked on the foot with impunity. The foot is twisted somewhat outwards, but there is tolerable motion at the ankle joint. She is able to digest stout, and it appears to suit her. She has continued ever since to take some form of stimulant, either stout or wine. She has often been threatened with gout in her toes, but has never had a definite attack. Her fingers are become affected by *nodi digitorum*, and she has been under Sir Alfred Garrod's care for effusion into the left knee. There are decided lips. Mrs. C—— is tall and thin (58).

No. XXXII.—*Effect of the Indian climate on Gout.*

Residence in India is beneficial to gout. Colonel S——, himself gouty, and inheriting in the strongest degree, tells me that his brother who serves in India is always well there, but gets an attack as soon as he comes to England.



## A CATECHISM OF SURGERY; WITH CASES FOR DIAGNOSIS.

### No. CLXVI.—*The Thyroid Gland.*

#### QUESTIONS.

1. Describe the operation of removal of the thyroid gland.
2. What precautions are of most importance ?
3. Why would you not remove the entire gland ?
4. What happens to the portion of gland left ?
5. What is meant by the term “cachexia strumipriva” ?
6. What is myxœdema ?
7. What is the supposed function of the thyroid ?

#### ANSWERS.

1. The gland is to be laid bare by a free crucial incision, the vessels are to be tied as they enter the gland, and the latter is to be carefully dissected out.

2. It is desirable not to cut or tear the gland-capsule ; no vessel is to be cut before it is ligatured, and some portion of the gland is to be left.

3. Because removal of the whole leads to a serious condition of ill-health.

4. The portion left behind usually takes on hypertrophic growth (Horsley), and discharges the functions of the whole.

5 & 6. Cachexia strumipriva is the state of ill-health which follows removal of the thyroid, and is much the same as myxœdema. In both the face swells and becomes featureless, and the skin and cellular tissue generally become thick and flabby. The mental powers fail, and the patient becomes weak and half idiotic.

7. It is believed that the gland has an important influence on the formation of red blood corpuscles.

No. CLXVII.—*The Treatment of Myxœdema.*

## QUESTIONS.

1. To whom do we owe the suggestion as to the treatment of myxœdema by administering the thyroid gland of animals?
2. What were the details of this method first employed?
3. Is it necessary to resort to hypodermic injection?
4. Is there any danger in the use of too large doses?
5. Has the experience of observers been tolerably uniform as to the good results obtained?

## ANSWERS.

1. As with most discoveries, there have been various steps. To Professor Kocher and Mr. Victor Horsley we are indebted for the demonstration of the connection between loss of the thyroid and myxœdema, and for the suggestion that the healthy gland of animals should be ingrafted. Dr. Brown-Sequard is to be credited with general and important suggestions as to the possible value of the juices of special glands injected subcutaneously. G. Vessale first made injections of the extract of the thyroid gland in dogs. To Dr. G. R. Murray, of Newcastle-on-Tyne, belongs the credit of having been the first to adopt the practice for the cure of myxœdema.

2. An extract of the thyroid gland of a sheep was prepared by mincing the gland and mixing it with glycerine and a weak carbolic acid solution. In this way a turbid pink liquid was obtained, and twenty-five minims were injected beneath the skin twice a week. The total amount for the week corresponded to one lobe of a sheep's thyroid. The frequency of the dose was gradually reduced.

3. It has been found that the gland is quite as effectual if given by the mouth, either mixed with beef-tea, or minced or thinly sliced and eaten as a sandwich. Of course it must be taken uncooked.

4. If the dose be too large the patient may suffer from vomiting, headache, and general malaise; but nothing more serious has occurred (with possibly one exception).

5. All observers seem to be agreed that this method of treatment is capable of curing the disease. The only point yet to be decided is with regard to the occurrence of relapses, after the administration of the gland has been discontinued.

### No. CLXVIII.—*Herpetology.*

#### QUESTIONS.

1. Does herpes ever occur within the urethra, and if so, under what circumstances?
2. What symptoms would lead you to diagnose urethral herpes?
3. What are the peculiarities of herpes when it follows quickly on constitutional syphilis?
4. How would you treat herpes when it occurs in a patient who has recently had syphilis?

#### ANSWERS.

1. Herpetic affections of the urethra, although not common, certainly do occur. The part affected is usually within a short distance of the meatus, although it is quite possible that it may occasionally be much lower down. It usually follows either syphilis or gonorrhœa.

2. Sometimes, without the use of the endoscope, a group of little white sores may be demonstrated. In most cases the diagnosis must be based upon the history. Repeated recurrences, short duration, and spontaneous recovery, imply herpes.

3. When herpetic affections occur in those who have recently had constitutional syphilis, they are apt to deviate from the rule of spontaneous recovery. The sores caused often linger for a time, or may degenerate into unhealthy ulcers.

4. If a patient who has recently had syphilis should become the subject of recurring herpes, whether on the genitals or within the mouth, the treatment should be compound. Both mercury and arsenic should be given. Arsenic is the specific for the herpetic element, and mercury for the modification of type which it will assume in connection with syphilitic taint.

No. CLXIX.—*Herpetology.*

## QUESTIONS.

1. Is herpes of the pharynx common ?
2. How would you diagnose a herpetic sore throat ?
3. Is herpes of the throat always in association with constitutional syphilis ?
4. When in association with syphilis, can it be prevented by the administration of mercury ?
5. What is the best remedy for the prevention of throat herpes ?

## ANSWERS.

1. Herpetic affections of the pharynx are not at all infrequent, and their recognition is very important.

2. As a rule, herpetic affections of the soft palate and pharynx are, like shingles on the body, strictly unilateral. Exceptions to this are, however, far more common than in the case of common shingles. This one-sidedness is a valuable means of diagnosis. It is aided by the grouping of the sores, by the great amount of tenderness which usually accompanies them, by the history of a sudden onset and tendency to spontaneous decline.

3. Most of the patients who suffer from recurring herpes in the mouth, whether tongue, cheeks, or throat, have previously been the subjects of syphilis. Some very characteristic and severe cases occur, however, without any such association.

4. The nature of the connection between syphilis and herpes is not well understood. As a rule, mercury does no good in preventing the latter.

5. Arsenic will usually prevent recurring herpes in the throat, whether it follow syphilis or not. It should be given for a long time, six months or a year, in doses of not less than three minims of Pearson's solution.

No. CLXX.—*On Suppression Methods of Treatment.*

## QUESTIONS.

1. What is the meaning of the term "suppression" as applied to the treatment of disease ?

2. Under what three names may our usual methods of treatment be roughly grouped?

3. In what diseases is the "suppression-treatment" to be recommended?

4. Is it possible to suppress syphilis?

#### ANSWERS.

1. The term "suppression treatment" is proposed as an improvement on that of the "abortive treatment," since the latter term is liable to be misunderstood. By suppression we mean an attempt to interfere with and prevent the natural evolution of any malady of which the stages are known.

2. We speak of preventive treatment, when we endeavour to anticipate and prevent the access of any special cause of disease. We may even extend the use of the same word to cases in which the cause having been applied we endeavour to take it away again, and thus to modify its effects. The term "suppression-treatment" may be suitably restricted to cases in which, it being impossible to take away the cause, we yet seek to counteract and prevent its effects. A third group of measures may be called expectant or opportunist. These terms are applicable when we are content to place the patient under favourable conditions for recovery and to allow the disease to run its natural course, interfering only when special complications arise.

3. We habitually practise what we may call suppression treatment under a great variety of conditions, and more especially in reference to local maladies. The idea that the malady should be allowed to run its course, "that it is better out than in," is one which, as our means of cure are multiplied, is steadily losing ground. Syphilis is, however, the malady, in reference to the treatment of which the term "suppression" receives its most definite application.

4. It is easily practicable, by the early and systematic use of mercury, to prevent the evolution of syphilis.

#### No. CLXXI.—*Ophthalmoplegia.*

##### QUESTIONS.

1. What is meant by the term "ophthalmoplegia"?

2. How is ophthalmoplegia interna distinguished from ophthalmoplegia externa?

3. Of what malady is ophthalmoplegia interna frequently a premonitory symptom?

4. Under what conditions is symmetrical ophthalmoplegia externa met with?

#### ANSWERS.

1. The term "ophthalmoplegia" is applicable to any form of paralysis of the muscular apparatus of the eye. It is convenient, however, to restrict its use to cases in which more than one nerve is implicated. As regards the latter, it is sufficient to name the nerve involved.

2. The term "ophthalmoplegia interna" is used in reference to the ciliary muscle and the iris, whilst that of "ophthalmoplegia externa" is applied to the muscles which move the eyeball.

3. Ophthalmoplegia interna, resulting in loss of accommodation and a motionless pupil, is not infrequently a premonitory symptom of tabes. When it stands quite alone it may be plausibly attributed to disease of the lenticular ganglion.

4. Cases of symmetrical ophthalmoplegia externa, in which both eyeballs become more or less fixed in the orbits and the upper eyelids droop, are seldom met with except in the tertiary stage of syphilis. They have, however, been known to occur after injuries to the head.

#### No. CLXXII.—*Dr. Meade on Erysipelas.*

Dr. Meade, a century and a half ago, wrote of erysipelas as follows:—

"Great attention is to be given to that fever which is accompanied with an erysipelas. For in this, besides the pain, thirst and restlessness, which the patient suffers, the pustules on various parts of the body sometimes run into gangrenes. Wherefore the first thing to be done is, to draw blood pretty plentifully, and then purge once and again with gentle cathartics, as infusion of senna with manna. For such only are proper in fevers. And indeed there is no acute fever that

bears repeated purging better than this, especially when the inflammatory tumour has seized the head; for the humour spreads very fast, and soon gains the neighbouring parts."

QUESTION.

In what respects have our opinions respecting erysipelas been modified since Dr. Meade wrote?

ANSWER.

Most will probably admit that it is more correct to speak of the fever which attends erysipelas than of the erysipelas which accompanies fever. Many, however, still adhere to the doctrine so distinctly avowed by Mead, that erysipelas is a fever, *i.e.*, that general blood changes precede local phenomena. All, however, have ceased to rely upon depletion as a measure of treatment. We now rely far more upon local treatment, and in doing so make a partial acknowledgment that we do not trust the doctrine of constitutional origin. Even in prescribing tincture of iron, as is now so properly and almost universally done, we look to the action of the remedy upon the blood vessels of the part rather than to any influence on the general health.

No. CLXXIII.—*Malformations of the Teeth.*

QUESTIONS.

1. How would you distinguish between the malformations of teeth due to syphilis and those consequent on stomatitis?
2. What are the peculiarities of the central permanent incisors, which are trustworthy as diagnostic of inherited taint?
3. May any other conditions be trusted for diagnostic purposes?
4. Are the malformations due to stomatitis in infancy often met with coincidently with those of syphilis?
5. Apart from the malformations of stomatitis and those of syphilis, what other peculiarities of the teeth may be recognised?

## ANSWERS.

1. The teeth to be looked at, in reference to the diagnosis of inherited syphilis, are the upper central incisors of the permanent set. Unless these teeth are malformed, all other defects are to be disregarded. The test teeth for stomatitis are the first permanent molars, and unless these teeth are defective in their enamel, any defects which the others may exhibit are to be disregarded.

2. These teeth ought to be smaller than natural, less wide at their edges than at their crowns, and with a single broad notch in the middle of their edge. These several peculiarities may be more or less well marked in different cases, but ought all to be present if the diagnosis is to be beyond doubt.

3. Many teeth are sufficiently malformed to cause suspicion, which yet do not justify a confident diagnosis. Many are also quite characteristic to a well skilled observer, which yet do not present peculiarities that it would be safe to describe as trustworthy.

4. Syphilitic teeth are very frequently seen in company with those which are malformed as the result of stomatitis in infancy. This results from the obvious fact that many, if not most, syphilitic children have been treated by mercury in infancy. This very frequent coincidence of the two kinds of malformation has led to much misconception as to what the true characters of syphilitic teeth are.

5. There can be little doubt that by far the larger number of cases in which the enamel formation is imperfect are due to stomatitis of some kind in infancy. Peculiarities in the form of the teeth, "rat teeth" for instance, may be met with without any assignable cause; and the conditions known as "craggy teeth" are occasionally a family peculiarity, and do not imply any preceding stomatitis.

No. CLXXIV.—*Errors in the Diagnosis of Small-pox.*

Amongst the cases which are sent into our Hospitals for Infectious Diseases there are always some in which the diagnosis, when it comes to be submitted to skilled specialists,



is open to question. Thus I find that Dr. McCombie, of the South-Eastern Fever Hospital, states that 25 out of 89 patients sent to him during one year as suffering from small-pox were found not to have that disease.

## QUESTIONS.

1. What eruptions are liable to be mistaken for small-pox ?
2. Are syphilitic eruptions often mistaken for small-pox ?
3. How should varicella be diagnosed from small-pox ?
4. What measures would be adopted in the event of a patient having been admitted into a small-pox ward and then found not to have the disease ?
5. Does chicken-pox ever cause death ?

## ANSWERS.

1. In nine out of ten cases the disease mistaken for variola is varicella. The remaining tenth is probably made up of syphilitic and lichenoid eruptions.

2. Yes, not unfrequently.

3. The rapid evolution without premonitory symptoms in varicella, and the contrast between the shotty papule of small-pox and non-indurated vesicle of varicella, will generally suffice. In severe varicella, however, the papules may assume a certain degree of hardness and there may be definite fever. In puzzling cases seek for freshly formed spots and note whether induration precedes the vesicle. In small-pox, induration comes first ; whilst in chicken-pox, if it comes at all, it follows the formation of a little pellucid vesicle.

4. The patient should be at once vaccinated and transferred to an isolation ward, where he should remain a fortnight.

5. The registrars' reports contain every year a certain number of deaths recorded as due to chicken-pox. They are probably, however, deaths after chicken-pox, and in consequence of its sequelæ, rather than during the fever itself. The sequelæ of chicken-pox are sometimes severe, multiple abscesses, &c.

No. CLXXV.—*Malformations of the Teeth.*

## QUESTIONS.

1. To what class of causes are defects in the milk teeth usually due?
2. In the subjects of inherited syphilis do the milk teeth usually wear well?
3. To what is the destruction of the milk set of incisors probably due?
4. Do the milk teeth ever present any peculiarities of form which are characteristic of syphilis?
5. How do you explain the fact that the milk teeth in inherited syphilis show no defects in their enamel as the results of mercurial treatment in infancy?
6. What peculiar condition of the eye is often met with in association with mercurial or stomatitis teeth?
7. How do you explain this association?
8. If a patient has had convulsions in infancy, and has yet taken no mercury, will any defect in his teeth be present?
9. Is it easy to make errors in diagnosis as regards the recognition of syphilitic teeth?
10. Are the conditions ever such as to warrant complete confidence?

## ANSWERS.

1. It is very probable that the use of mercury by a pregnant woman, in a late period of gestation, may cause damage to the enamel of the first set of teeth. Stomatitis, whether mercurial or otherwise, if occurring in the first few months of life, may very possibly damage the first set of teeth so as to cause early caries.
2. No; it is very common for them to "rot away," as it is said, by caries which begins at the crown. Syphilitic children are often, as regards their incisor teeth, wholly without them for several years before the permanent set comes up.
3. It is very possible that this is due to the use of mercury during the first few months of life.
4. No; they are almost invariably well formed, but are liable to early caries.
5. The crown of the tooth is usually well calcified before

the mercury is given, whilst the neck and fang have yet to be formed.

6. The subjects of what is known as lamellar cataract almost invariably present those defects in the formation of enamel which constitute what are known as the mercurial teeth.

7. Lamellar cataract is usually met with in those who have suffered severely from convulsions in infancy, and it is to the use of mercury for the relief of the convulsions that the defects in the teeth are due.

8. There is good reason to believe that the convulsions have no direct influence on the teeth, and that the spoiling of the latter is due only to the remedy used.

9. Yes ; the conditions are often so ill-marked that great care is necessary in their appreciation.

10. When well characterized they may be trusted implicitly.

#### No. CLXXVI.—*Questions without Answers.*

Is the presence of a brain necessary to perfection in the development of the limbs of a fœtus ?

Is it possible for a fœtus to live and grow without any central organ of circulation ?

What is the incubation period of small-pox ?

At what period after contagion may a chancre be expected to show induration ?

Is measles more dangerous to a child or to an adult ?

Is it possible to successfully inoculate calves with human small-pox ?

What is the difference between vaccination and variolation ?

What is the conventional distinction between mortality and fatality ?

Which nerve of the brachial plexus is the most liable to injury in dislocation of the humerus ?

Where does the head of the humerus usually rest in dislocation downwards ?

Can varicella be transmitted by inoculation ?

What disease is often miscalled sciatica ?

Of what do gout tophi consist ?



## PLATE LXIX.

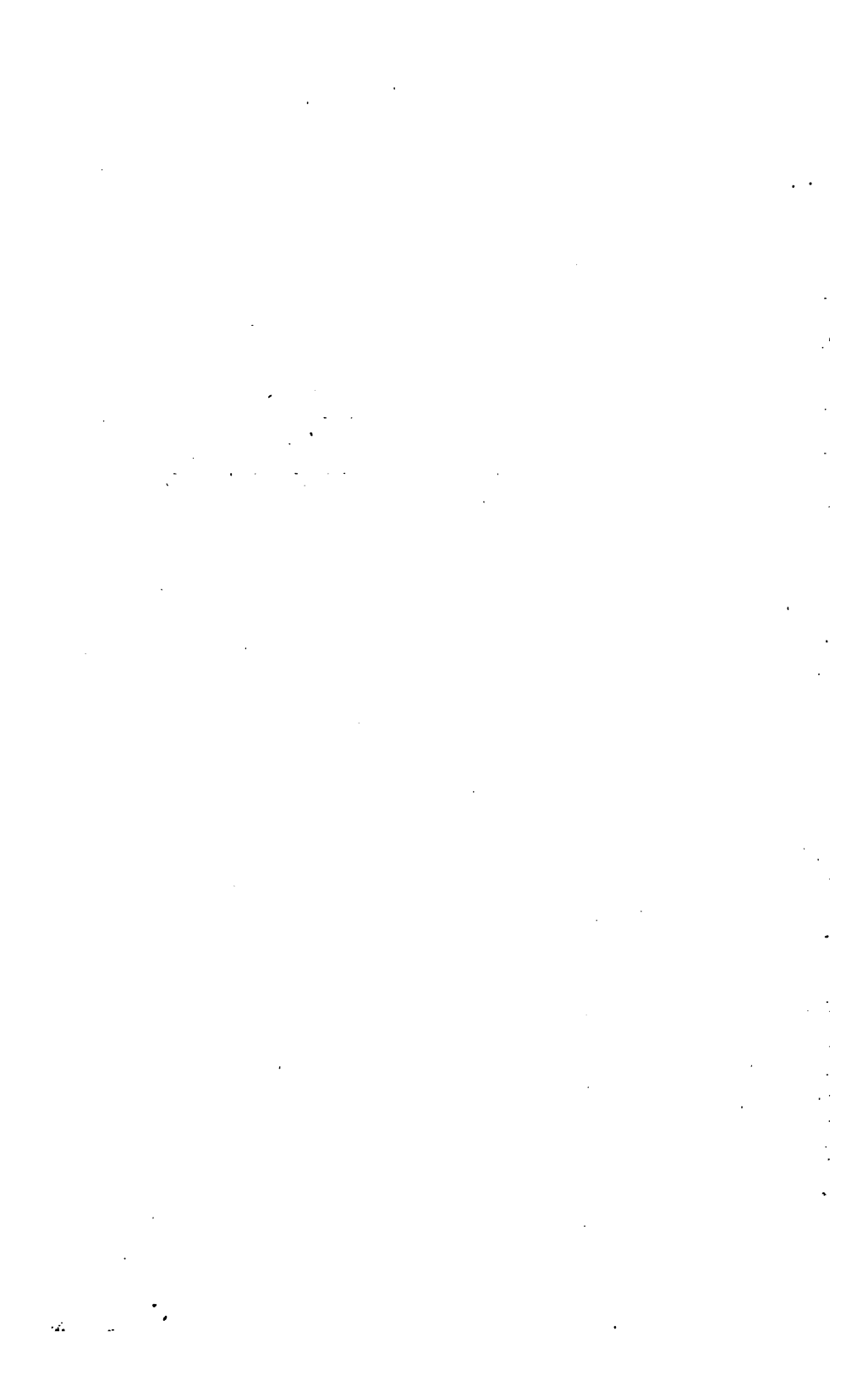
### KAPOSI'S DISEASE.

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THIS lithograph has been copied from a portrait kindly lent to me by Dr. Radcliffe Crocker. It is taken from a patient whom I have myself seen. I reproduce it on the present occasion, in order to illustrate the proposition that the malady known as Kaposi's disease ought to rank as a family form of lupus. It has perhaps a nearer relation in certain particulars to lupus erythematosus than to lupus vulgaris, but it probably partakes of the characters of both. It might possibly be suitably known as lentigo lupus, or the lupus that attacks freckles. It is a family disease, almost always attacking three or four members of the same family, and commencing in early life. It is clearly evoked under the influence of exposure to sunlight, and its first stage is one of extensive freckling, affecting the face and hands. Next follows a stage of ulceration, and bossy masses of granulation grow out; and finally there is a tendency to develop fungating masses, which are of the character of epithelial cancer. In most of these features it has close parallels to certain cases of lupus. In the portrait given it will be seen that the girl's neck is covered with freckles. The tip and alæ of the nose have been destroyed, almost in the same manner so often seen in lupus; whilst on various parts of the face, more especially just in front of the right ear, there are ulcers, covered by bossy masses of soft granulation structure. That on the ear was, I believe, already carcinomatous. Three or four brothers and sisters suffered from the disease. The cases have been fully published by Dr. Radcliffe Crocker in the 'Medico-Chirurgical Transactions.'









## PLATE LXX.

### LUPUS VULGARIS AFFECTING THE NOSE AND LIPS.

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THIS Plate is the portrait of a young lady who died of pulmonary phthisis about a year after it was taken. She was of a somewhat delicate family, and one of her sisters suffered from lupus of the septum nasi. There was no syphilis in the case. The portrait was taken in order to show the very extensive ravages which occasionally attend lupus when it attacks the lips. It will be seen that the whole of the parts around the mouth have been destroyed, together with the entire upper lip and a great part of the nose. The ulcer was usually crusted over with a thick scab, and readily bled when the latter was removed. The treatment had, in the earlier part of the case, unfortunately been neglected, on account of the patient's unwillingness to submit to the pain which it caused. Had she survived, it is probable that the final condition, after cicatrisation, would have resembled that shown in the woodcut given at page 876, Vol. IV.







## PLATE LXXI.

### LUPUS MUTILANS.

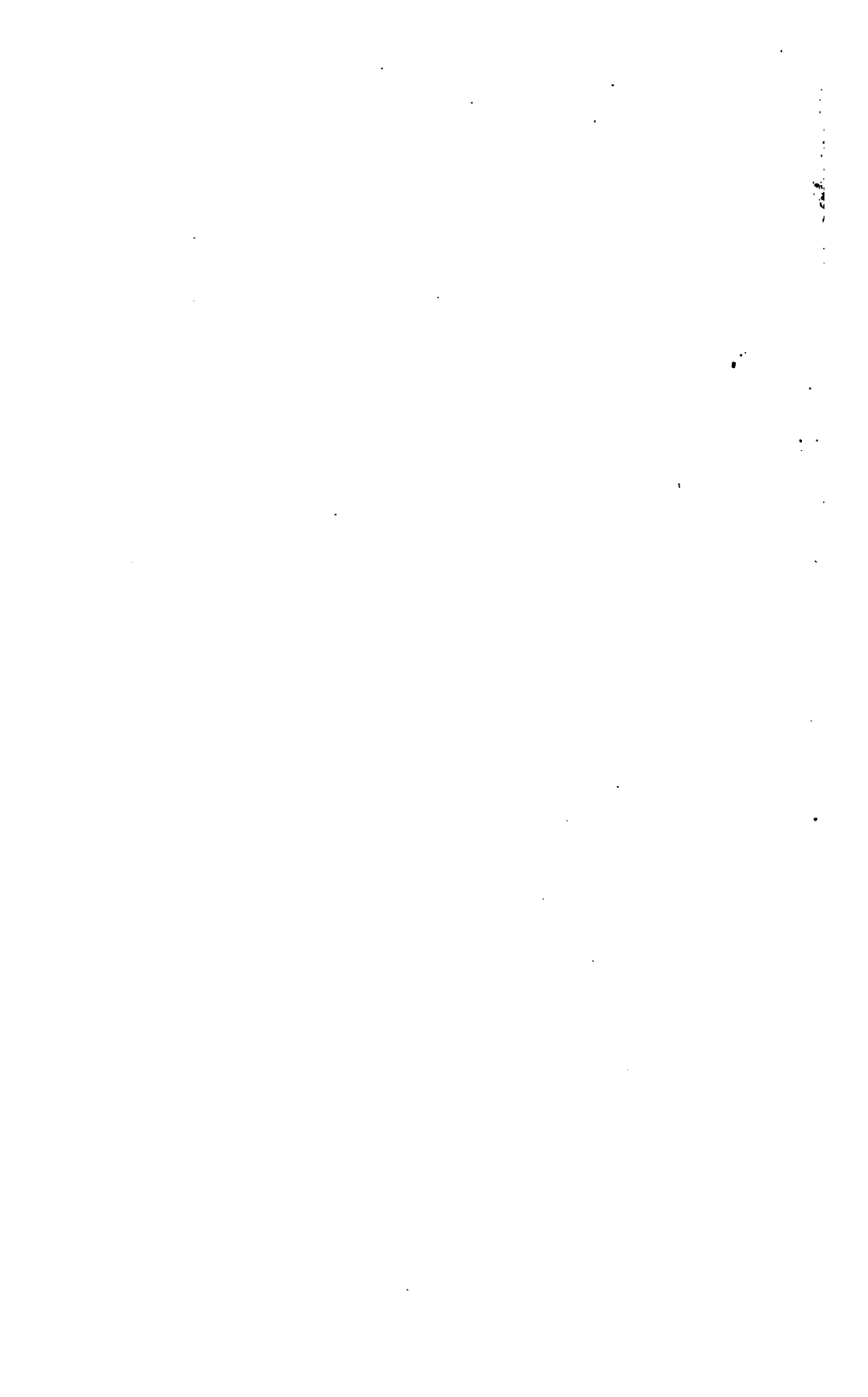
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IN this lithograph we have shown the hand of a young woman, in whom lupus had commenced in early childhood. The skin of the entire hand and of the lower part of the forearm had been reduced to a condition of scar. The two ulnar digits had been entirely destroyed, and the other three shortened and deformed. The mutilation much resembles that which is sometimes seen in cases of leprosy. It had been brought about partly by inflammation of the bones of the digits and partly by their interstitial absorption.

I have seen but very few cases of lupus mutilans resembling the condition here shown. In all it was associated with lupus vulgaris on other parts, and in all the disease had begun in early life. It is, I suspect, necessary to the production of the exaggerated conditions here shown, that the disease shall begin in youth, and that it shall spread over the whole hand. The late Mr. Sibley once brought to me a patient, suffering from lupus of the face, one of whose hands was exactly in the condition shown in this Plate. She was a lady of about thirty years of age, and had suffered from childhood. A similar condition is sometimes produced in the foot.







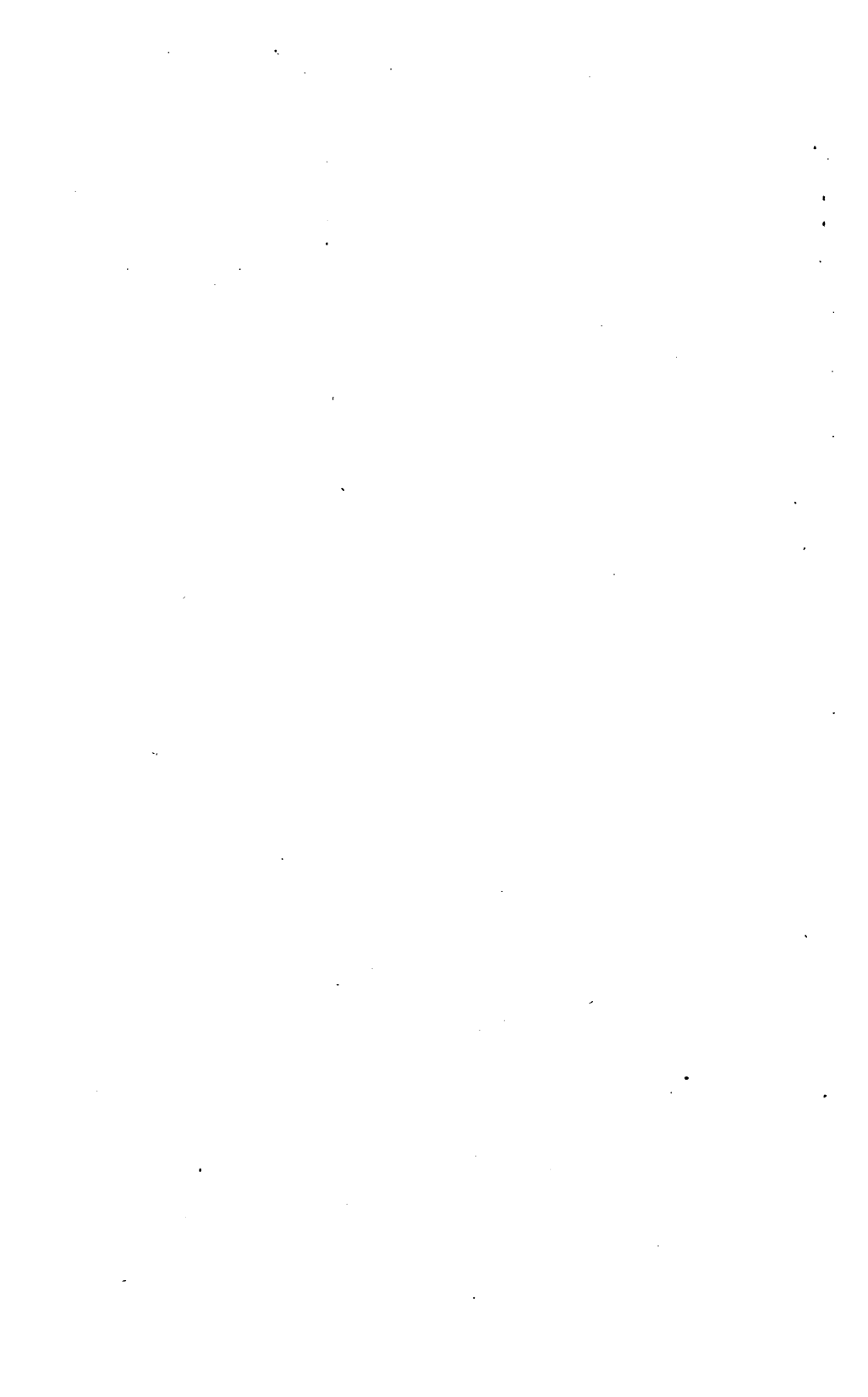






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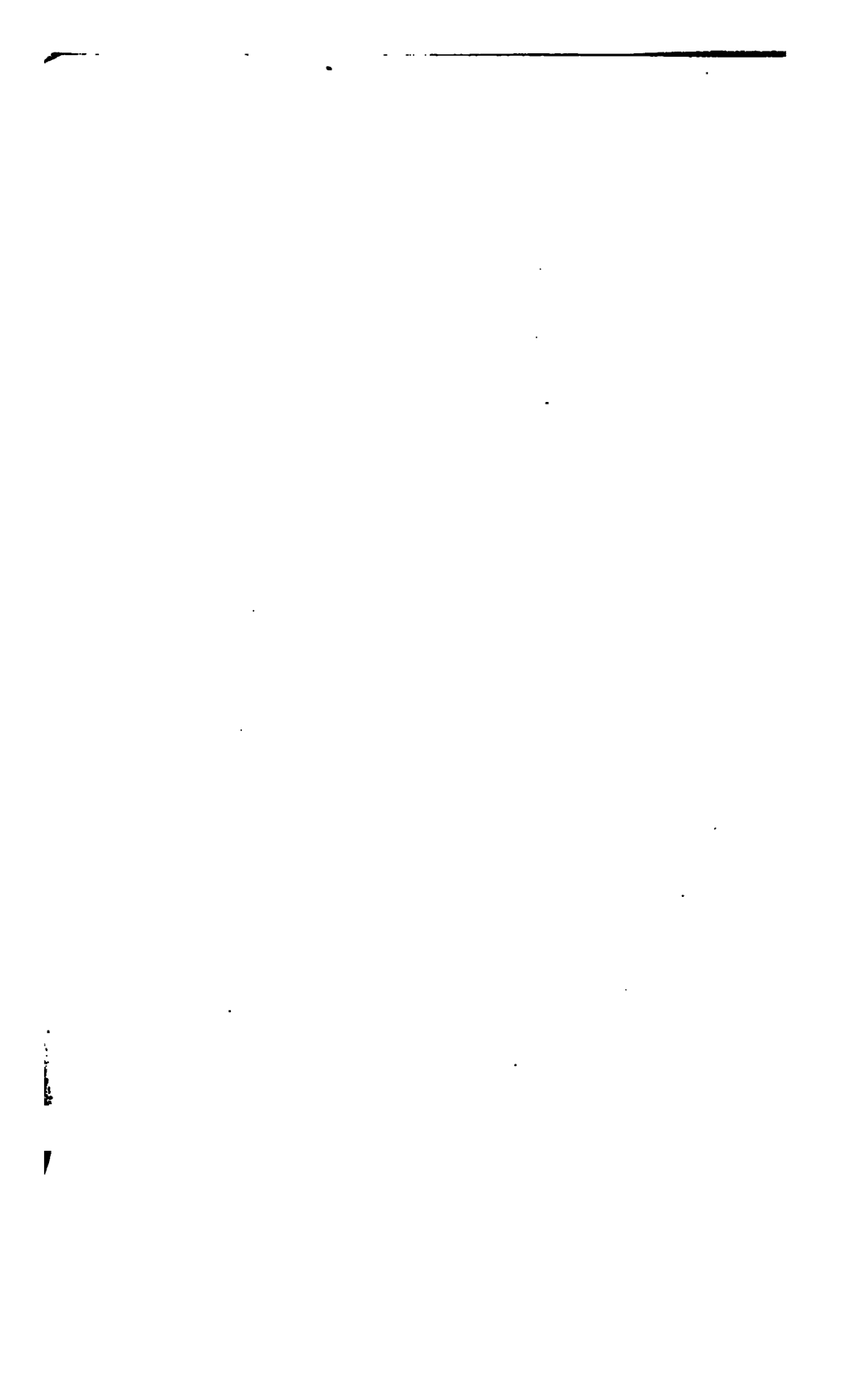
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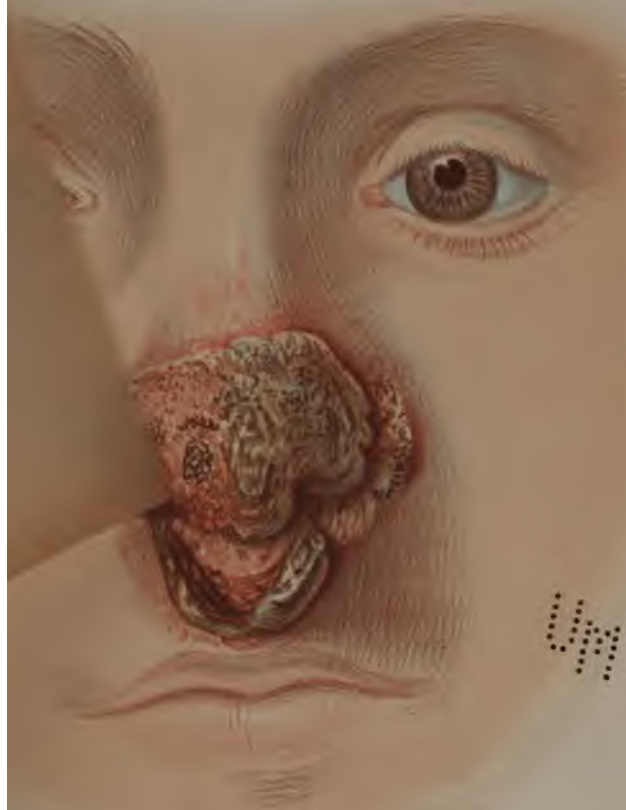


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1791





# ARCHIVES OF SURGERY.

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OCTOBER, 1893.

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## BAZIN'S MALADY. MULTIPLE ULCERS ON THE LEGS.

*(Concluded from page 42, with a Plate.)*

I DESCRIBED in the last number of ARCHIVES eight cases illustrating a condition which may perhaps, for the present at least, be most conveniently known as "Bazin's Malady." They are cases, as was then stated, in which multiple ulcers occur on the legs of young persons, which are probably of a more or less scrofulous nature, but which assume features much resembling syphilis. I should like to insist definitely upon the following points:—

1. That, although the most typical examples of this malady occur in young persons, and most frequently in girls, yet that the disease is not restricted either by sex or age.

2. That, although the lower extremities—the legs—are the parts most frequently affected, there is yet no positive limitation to these parts.

3. That, although definite scrofulous antecedents, or accompaniments, may be proved in some of the cases, yet there are others in which this cannot be alleged.

4. That, although the malady in well-characterised cases presents very definite peculiarities, yet that there are a great number of ill-marked cases, which are probably of the same nature, but which do not present features sufficiently definite to allow of their being grouped.

5. That, although in well-marked examples of this malady we may most definitely exclude syphilis, it is yet quite probable that in certain cases (indistinguishable by their symptoms and not to be diagnosed without risk of error even by the test of treatment), there is a double causation; and a remote taint of syphilis has to be taken into account.

It may be suspected as regards these cases that they are by no means well specialised, and that they result from a combination of causes rather than from a single one. It is scarcely probable, even in the most typical of them, and those most definitely associated with scrofula, that the sole cause is the implantation of the tubercle bacillus. Their frequent limitation to the legs is probably to be explained by the peculiarities of the circulation on those parts. Their preference for young persons, and girls in particular, is probably due to the abundance in them of subcutaneous cellular tissue. It is not unlikely that exciting causes are frequently present, such as slight injuries, thorn-pricks, or insect-stings. The essential feature in their final development is that the inflammatory products which attend them become locally infective. Upon this fact rests the explanation of their multiplicity, and upon its full recognition depends our success in treatment.

The cases, which I have already narrated, are eight in number, and seven of them occurred in girls. I shall now proceed to give the particulars of some other cases. Before doing so I may direct my readers' attention to an interesting paper on the same disease by Dr. Colcott Fox in a recent number of the "Dermatological Journal."

**CASE IX.**—*Multiple Ulcers on both legs in an adult woman—The arms also affected—Gland disease in neck—Liability to pustular ophthalmia—Details of treatment extending over eight years—Cure, but with tendency to relapses.*

This case is the one mentioned at p. 353 of my book on Syphilis. When the lady who was its subject first came under my observation, I was disposed to believe that it was a case of syphilis, and this diagnosis had been given by those who had previously seen her. Our suspicions were confirmed by the fact that the patient's husband admitted having



had some venereal sore before his marriage. They were further strengthened, during the course of treatment, by the fact that much improvement occurred during the use of mercury internally, as well as for the sores. I have now had this patient under my observation for eight years, and have repeatedly seen her husband and several of her children. I do not now feel any doubt that her malady was not of a syphilitic nature. The report of the case, which I published in my book in 1887, was much abbreviated; and as a number of new facts have come to my knowledge since that date, I think it may be worth while to begin at the beginning and publish now the whole of my notes concerning it. It is one of very considerable peculiarity and interest.

Mrs. D——, a lady of thirty-eight, florid and looking quite healthy, was sent to me by Dr. C——, of L——, in March, 1885. Both legs were severely affected, and she had in fact kept her bed or couch for nearly three months. On all parts of the legs, but chiefly on their backs, from a little below the knee to near the ankles, there were scattered dusky or livid indurations. Some of these were superficially ulcerated, and showed scabs; others not so; some had healed and left scars. Dr. C——'s note described them as having been "deeply punched-out, and when healing covered with a rupia-like crust." Under his treatment these characters had been much modified, but still the places had not become sound, and fresh sores still appeared. The initial lesion was always a small livid induration in the subcutaneous tissues, not a bulla. Mrs. D—— herself said that none of them had ever spread much at their edges, or become what she called "running sores." We may therefore take it that none had been definitely serpiginous. There were a few small blotches above the knees. On the back of each arm, just above the elbow, was a group of dusky spots, none of them much indurated, and none ulcerated. They were clearly of the same type as those on the legs, though very much less developed. Mrs. D—— had no other skin disease, but in the left side of her neck were two scars of strumous abscesses, probably glandular, one of them not yet sound.

Although Mrs. D—— looked well, I was assured that, before the spots began to appear, she had been nervous and much out of health. The first sore was on the right leg and single. This was six years ago, and since then, with many periods of partial cure, they had been increasing in number. In the hope of getting rid of them, she had for three successive summers spent six weeks at Royat and submitted to vigorous water treatment. On each occasion her health had benefited, but the sores got worse. After her return home, however, the sores often nearly healed. This year they had not done so, and from her return in August to Christmas they had been getting worse. Dr. C—— wrote to me that about Christmas he had prescribed the solution of perchloride of mercury with iodide, "increasing the dose to as much as she could bear, and with very good results." For six weeks, however, this treatment had been suspended, and, in spite of steel, arsenic, and ammonia, fresh places had

appeared. At Royat no specific treatment had been pursued. Thus it will be seen that the evidence from the influence of remedies was in favour of syphilis; but it must be noted that Dr. C——'s treatment, although beneficial, had by no means effected a cure, and the relapse had been very speedy when it was left off.

The facts as to syphilis in the family history were as follows: Mr. D——, her husband, had two years or so before marriage suffered from a venereal sore. So far as he remembered, it lasted only a few days, and no secondary symptoms had followed. There had been no reminders. I saw him, and he appeared quite well. They had been married thirteen years. The first conception ended in a miscarriage, the next in a live birth, and the child, a girl, was now living, and had never presented any suspicious symptoms. There were four other living children, and had been two other miscarriages. Nothing had ever been noticed in any of the children to lead to suspicion. Mrs. D—— during the early part of her married life had been quite well, but she thought that rapid child-bearing had weakened her, and after one confinement she had had a white-leg. Her youngest child was now four. There was a tubercular tendency in her family, and a sister and an uncle had died of phthisis. She herself, when a girl of eleven, was sent abroad on account of suspected lung disease, but had never since had any symptoms of it.

*April 19th, 1885.*—They begin as *little indurations or knots* under the skin, which are very slow in progress, but soften gradually. She has been slightly salivated, but without any definite effect on the legs. Some fresh places are coming, and some have faded. On the whole, improvement. Has been walking well.

*May 18th, 1885.*—The benefit from the mercury appears to have been definite and considerable. Almost all the places have healed, and she can walk with comfort. She is staying at Hastings, and going out regularly. The gums are still decidedly sore. It is to be noted that, although the ulcers have healed on the legs and the induration beneath them almost wholly disappeared, yet the little knots on the backs of the arms remain much as they were. These are placed in symmetrical groups behind each arm, just above the elbow. They are not larger than peas, and none of them ulcerated. Even on the legs, whilst most have got well, a few new ones are threatening. I suspect that the indurations begin around venules, or possibly they are lymphatic.

*June 20, 1885.*—Mrs. D—— afterwards stayed at Westgate-on-Sea for six weeks longer, and much improved in health. Her legs also continued to get better, and when in June she returned to L—— they were all but well. Still, however, some subcutaneous indurations persisted both in the legs and above the elbows, but they showed no tendency to break down. She had been taking specifics all the time.

*October 15, 1885.*—She looks well, is florid, but the legs are little or no better. The primary lesion is not always the same; some begin as hard knots under the skin, and others as bullæ or small erythematous patches

which vesicate. There are no large ulcers on the legs, but several low rupia-like scabs. The tendency to form a rupia-scab is quite definite. When the subcutaneous knots inflame, they vesicate before they ulcerate. Both upper extremities are rather worse—that is, the spots and knots are more numerous, and some of them are inflamed; none of them are large. She has taken for the last month eight grains of iodide and a drachm of Liq. Hydr. Bichl. She has lost flesh, and feels weak, although very florid and looking well. When not taking medicine, she feels perfectly well. I now advise her to try inunction of mercury to slight pytalism.

*November 24, 1885.*—Since October 15 she has been rubbing in half a drachm of strong mercurial ointment every night. Her health has been excellent, and there has been no pytalism or diarrhoea. The arms are nearly well, but the legs are not well. There are now no bad ulcers, but several indolent dusky sores with crusts. None of the places heal quickly. She walks about a good deal. Whilst using the Ung. Hydr. she has also been freely applying a lotion of sulphate of zinc (a drachm to ℥ij). She thinks that this lotion has suited well. No pain whatever. In excellent spirits. Last winter she was in bed most of the time on account of the soreness of the legs.

*February 23, 1886.*—Ever since Oct. 15 we have been rubbing in half a drachm of strong mercurial ointment every night, that is for about four months. The rubbing has usually occupied half an hour, and it has been done with almost absolute regularity. The result has been that the places are almost all healed. Those on the backs of the arms have quite disappeared. On the legs the cure is not so complete, and much induration remains about some of the scars, but there are no ulcers. Mrs. D— is in excellent health. The prolonged inunction has agreed well. She is florid, has good appetite, and sleeps well; she says that she never felt in better energy in her life. The only drawback is an occasional headache in the back of the head. Her legs now allow her to walk a great deal, and she is constantly about. Any one looking at the legs now for the first time would unhesitatingly declare them syphilitic. They are covered over the calves with depressed scars, which are dusky at their margins, and some of them having hard lumps extending into the cellular tissue around them. The question still remains, Are they syphilitic? and it is perhaps not even yet quite set at rest by the good results which have followed mercurial inunction. She had previously benefited much from change of air to the seaside and to Scotland. In November, soon after the inunction was begun, her residence was changed from L— to a very healthy elevated spot above B—. This change seems to have suited her health well. If syphilitic, its symmetry on both arms and legs is certainly remarkable, and so is the fact that it has not yielded more definitely to specific treatment, more especially to the continued pytalism which at one period we maintained. It should be added that quite recently she has had a small abscess on the left side of her

neck. It was not apparently glandular. There is an old scar of an abscess near it, which she says occurred soon after her marriage.

June 24, 1886.—The legs and the arms have been nearly well through the winter. Has been laid up with “phlyctenular conjunctivitis,” and lost her voice. She left off using the mercurial inunction. Her legs, which had been quite well, relapsed.

There are now single *symmetrical* nodules under the skin above each elbow; very hard, rounded, movable, but adherent to skin. Above the elbows are numerous little scars of former sores. Her legs are still nearly well, but with a decided tendency to relapse. There are a few scabs on old scars, and a few subcutaneous indurations which are new. She seems to be threatened with rheumatism of left hip.

October 7, 1886.—I have not seen her since June. Since then she has used “sixty boxes” of the Ung. Hydr. for inunction; half a drachm every night. She has been very well all the time, “better in health than for years.” Not the least pyalism. Most of the sores on the legs are quite well (depressed scars with pigment at edges). A number of subcutaneous indurations still persist, and a number of fresh sores have formed. These are chiefly above the ankles, but there is one on the knee, and on the arms near the wrists are a group of them. On the arms they begin more distinctly in the skin itself, like little boils, whilst in the legs they begin under the skin. The eyes have been inflamed again.

November 2, 1886.—She is in excellent health, “excepting when I take the medicine.” There are still numerous sores on both legs, and a few on the forearms. They have undermined edges, and are very chronic in all their conditions, and but little inflamed. She has recently used an ointment of iodol., and taken bichloride with iodide. The fact that fresh places develop on the arms discourages us from the use of caustics.

November 30, 1886.—It is just a month since I saw her. She has had the mouth decidedly sore. She was obliged to interrupt the pills, which were Hydr. Subchlorid. gr.  $\frac{1}{2}$  and Pulv. Opii. gr.  $\frac{1}{3}$ , quater die. There was pain and diarrhoea. The effect of the salivation was to dry up the sores on the legs, but they have not healed soundly. On the backs of wrists the sores have healed, leaving dusky livid scars. There is no doubt that all the sores on the legs have healed under the mercury.

Mrs. D—— is quite well if she takes no medicine (iodide).

February 23, 1887.—I have not seen her since November 30, 1886. She then took home with her thirty half-drachm packets of “Lano-liniment mercuriale,” as dispensed by Martindale, and has used them. For some weeks none have been used. They produced no effect on the gums, and did not disagree in any way. The result has been that all the sores are quite healed. Some of the scars have horny scale-crusts on them, but they are sound and show no inflammation. The inunction has been left off for two or more weeks, and there has been no relapse. All the places on the arms are quite well. They have left dusky scars above the

elbows and along the backs of forearms. She is in excellent health, but complains that she feels nervous and does not walk so well as others. She walks, however, far better than a year ago. The local treatment has been an ointment of iodol and yellow oxide of mercury. She likes this ointment, and says that it has suited better than any other. As making it probable, however, that it has been the constitutional treatment, and not the local application, which has cured, it may be mentioned that the "little knots" under the skin of the arms have all melted away, and the ointment has not been used to them. It has been used only to the local sores.

*August 23, 1887.*—Has been in Switzerland, and walking much. Has been quite well for six months. Left off inunction in February. She left off all treatment before the sores were quite well, but they were rapidly improving, and the improvement continued. The cure is now complete. The legs are covered with scars, the margins of which are very deeply pigmented. There are also a number of little scars on the backs of arms just above the elbows, and one or two on backs of wrists. She is very well. Menstruation appears to be ceasing, but she feels well.

*November 2, 1888.*—She has had some fresh spots on the legs. She has a favourite ointment of mine, which she says always heals the sores, "but it takes a month." It contains iodol and yellow oxide of mercury. Her left leg is sound, with many dusky scars; the right has a few small ulcers. She looks very well. There are no spots on the arms. She has had little or no treatment for a year past, and has done very well.

*July 19, 1892.*—It is now eight years since I first saw Mrs. D——, and for four years she has been well. She is suffering from a slight relapse of ulceration on the legs; and pustular ophthalmia of the right eye is threatening (this afterwards developed into a severe attack).

*October 13, 1892.*—Her eye is now almost well, only two small pustules remain opposite each other and opposite the canthi. She looks very well. Her legs are quite well with the exception of one very small ulcer and one subcutaneous induration.

My last note concerning this remarkable case is as follows :

*May 12, 1893.*—She has a single, quiet pustule on the edge of the cornea. It has been present a month. She says that she had it last September much worse than now. It was then, as now, confined to the right eye. The legs are almost healed (under the mercurial ointment). She has a spot on the back of the left arm. Some spots which had threatened on the face have most of them disappeared. "The ointment is splendid."

The reader will, I trust, pardon the length of the above narrative, for the case is instructive not only in respect to the nature of the disease, but also as a lesson in therapeutics.

More or less under the influence of a mistaken diagnosis, specifics were, as we have recorded, used very freely and through very long periods. Repeatedly the gums were made sore. The patient was a somewhat fragile woman, who in early life had been threatened with phthisis. Yet no damage to her constitution resulted from this use of mercury during several years. She was always well whilst employing it, and she is now in excellent health and looking much younger than her years. These statements apply to the mercurial part of the treatment, for when the iodide of potassium was combined with it, loss of strength and flesh invariably followed. It is further to be stated that although specifics failed to cure the disease, and failed so completely that we may infer from their failure that the malady was not specific, yet mercury always did good. The general deduction may be fairly made that mercury does not injure the nutrition in scrofulous persons, but rather the reverse.

As to the pathological lessons of the case, attention may be asked to the following points :—

1. The patient was not improbably not only scrofulous but actually tuberculous.\* She had been suspected of phthisis in early life, and brothers and sisters had died of that disease. It may, therefore, easily have been the fact that tubercle bacilli were extant in her frame ready to develop when opportunity offered. Yet during her long illness no symptoms of lung disease ever occurred, nor, with the exception of a slight relapse in an old focus in the neck, was there any tendency to enlargement of glands.

2. The case well illustrates the remarkable tendency to relapse which there is in this disease. These relapses were probably in part due to season and changing conditions of general health, but mainly to the existence of infective material left over in the skin in a quiescent state.

3. In passing we may note that so great repeatedly was the apparent benefit from mercury, that the original diagnosis seemed to be confirmed. A fallacy of course underlies all our

\* I use the terms "scrofula" and "scrofulosis" for all that belongs to the state of tissues favouring the development of bacilli, but without their presence, and "tuberculosis" for what results from their actual presence.

inferences as to the effects of the remedies which were given internally, for at the same time we were using various local measures. Nothing is easier than to mistake for the effects of medicine what is really the consequence of some local application. In this instance I believe the cure was effected mainly by the ointment. This belief is strengthened by the results in several other of my cases. In the ointment, however, it was again mercury which proved curative.

4. The case shows beyond question that there is a tendency in the disease to affect the backs of the arms and even the wrists as well as the legs, though much less severely than the latter.

5. It also shows what is very important—a tendency for recurring attacks of pustular ophthalmia to be associated with the skin affection. The connection between pustular ophthalmia and scrofulosis has long been a puzzle for ophthalmological nosologists. For myself I have long held that there is undoubtedly a connection between the two, and that the occurrence of pustules (or phlyctenulæ) around the cornea is an indication of a scrofulous habit of body. Are they tubercular in the modern sense of the word? This may be doubted. As in the case before us, they are often recurrent, heal perfectly after a short duration (especially when treated by mercurial ointment), and but seldom lead to chronic ulceration.

CASE X.—*Furunculoid and ulcerating eruption on the legs, producing sores and scars which looked like those of Syphilis.*

The case of Mrs. B——, a lady whom I saw with Dr. P—— C——, was, like the preceding one, very puzzling. She had an eruption, placed almost symmetrically on the two legs, which began as painful tubercles which ulcerated and spread superficially. Some of the ulcers were as large as a child's palm, and had dusky tuberculated edges very like those of syphilis. Yet there was no history of syphilis, and the patches were symmetrical, and there were none on other parts of the body.

I saw her first at my own house in November, 1884, and then a second time on February 19, 1885. On the second occasion I was told that the ulcers had healed for a time but had now relapsed. There was now a tendency to spread up the thighs, a few inflamed tubercles, almost furuncular, being present on the outer sides of both thighs.

The history which I got was that Mrs. B—— had been married some years and had two children, the youngest eighteen months old. Both children were quite healthy. After her last confinement Mrs. B—— had measles, but they passed off well, and for ten months afterwards she had tolerably good health. It was in August of 1884 that the spots on the legs first showed themselves. She knew of no cause, and was not specially out of health at the time. The house was supposed to have had bad drains, but no one else suffered. Dr. C—— had tried iodides, arsenic, and mercury, but without result. Nor had iodoform or black wash seemed to suit locally. A suspicion crossed my mind that the so-called measles might possibly have been syphilis, but I was assured that it was quite transitory. There had never been any sore mouth or throat. There was no history of syphilis in her husband.

In December, 1885, I saw Mrs. B—— for a third time, and made the following note: She went to Brighton in the beginning of March, and remained there two months. She was worse at first, then better. My pill of Hydr. cum Cret. with iodide made her mouth very sore, and she left it off after two weeks. Since then she has taken my prescription with arsenic and small doses of opium. She has been improving all the time, and has been at times without a single open sore. She does not think that the salivation did her any special good. She was improving before, and has continued to do so since. For two months she has worn elastic stockings, and can now walk fairly. All the sores are healed excepting two little ones on the right leg. She has a copious eruption of lichen-acne on forehead and face, and she thinks that her complexion has become much darker. (Query from the arsenic.) Her general health is better, and she feels stronger. Still liable to neuralgic headaches in back of neck and head. Has taken for nearly nine months:—

Liq. Arsenic. m iij.  
Tinct. Opii. Sed. m ij.  
Tint. Nuc. Vom. m x.  
Ter die ex aqua.

Thus it remains uncertain what has effected the improvement. She has used continuously a weak sulphate of zinc lotion, which has suited better than the ointments did. It may be that the small doses of opium long continued have done something. On the other hand, we must not forget the short but definite salivation.

The case differs from Mrs. D——'s (Case IX.), in that there is no affection of the skin above the elbows, although there have been a few below them, and that on the legs the disease is confined to their front aspects. The little subcutaneous tubers have been also less well-marked than in Mrs. D——. The characters of the ulcers produced and the scars left are exactly alike in the two.

The following case is one of the most characteristic and severe in my series. I have also the satisfaction of being



able to illustrate it by a good portrait, and to record a complete cure. Great interest had been taken in the case by several of my surgical friends, before the lad came under my care, and long periods of rest had been enforced. The cure was finally effected under free exercise in the open air. I believe that one observer thought that he had recognised tubercle bacilli in portions which had been cut for examination from the edges of the ulcers. I record the case, like the preceding one, in considerable detail, because it is necessary to secure the means of judging accurately as to the effect of different methods of treatment.

CASE XI.—*Multiple ulcers on both legs in a boy—No history of Syphilis—Intractability under treatment—Final cure by exercise, tonics, sea-air, and local applications of mercury. (See Plate CIII.)*

I first saw Master R. R.— on June 15, 1891. He was a healthy-looking boy, aged 12 years, and was brought to me on account of sores on the legs. These were first noticed at Easter, 1890, and then presented the appearance of "little red spots, looking as if a core had come out of a boil." A month later he was under the care of Mr. E. O—, but in spite of treatment healing was slow. He was quite well for three weeks before Christmas, 1890. Most of the sores had healed in the summer, but all of them from time to time broke out afresh.

At the time of his first visit to me his legs were covered with scars, some of which were large and deep and involved the cellular tissue. A few spots had also occurred on the scalp, and one on the back of the upper arm. They had not been painful, and he would walk if he were allowed. His circulation was languid, and his feet liable to get cold in bed, though not in an extreme degree. Before the appearance of the first sore he had a broken chilblain on one toe.

I was told that on January 7, 1891, albumen had been detected in his urine, but I could find no trace of it at the time of his visit. Master R.— has three brothers and one sister, none of whom are ill, and amongst these he is fourth in order.

A week later (June 23), under treatment by iodoform ointment and liq. arsenicalis, the sores were all of them much better, and some were looking quite healthy. On July 23rd there was further improvement in the legs, and liq. arsenicalis was still taken twice a week.

I again saw the patient on September 16th, after he had spent seven weeks at Cromer, where his health had been excellent. Healing was slowly going on. Many of the sores had healed, and all looked healthy and superficial. There had been no spreading of the old ones, and no

fresh sores had appeared (with a single exception), although some had broken again after healing.

The treatment had been—*Liq. arsenicalis* twice a week and *liq. hyd. perchlor.* with *cinchona*. The ointment used had contained iodoform and yellow oxide of mercury. I advised a further stay of six weeks at the seaside.

On October 29, 1891, Master R— again came to me. He had then been almost a year at the seaside (Folkestone), and had remained in good health. The ointment and internal remedies mentioned above had been continued, and in addition I had cauterised the sores once with acid-nitrate of mercury.

The legs were still covered with little ulcers, which discharged a good deal of glairy pus, and would easily bleed. They were much more superficial than formerly, and had shelving in place of undermined borders; but during the last six weeks none had healed, and three or four fresh ones had formed. The ulcers were sore after the dressings, but the skin between them was not in the least inflamed. The old scars were perfectly sound; they were not nummular but shelving, and not in the least pigmented. All the sores were florid, but smooth and destitute of granulations, and none remained above the knee. There was no roughness of the backs of the arms. The disease seemed to affect the cellular tissue rather than the skin.

On October 29th I changed the treatment, and ordered quinine and steel, and for one leg an ointment of bisulphuret of mercury, gr. ii. to the ounce, and for the other leg a lotion of nitrate of silver (gr. xx. ad ʒi.) to be applied on lint.

On December 10, 1891, I found that under the lotion some of the sores had healed quickly, but that they had broken out again soon afterwards. Those dressed with the ointment were for the most part healed. Almost all the sores were healed, and all looked healthy. The patient had been taking quinine and *nux vomica* internally. He had been living at home, and had been walking a good deal every day.

I may briefly summarise the subsequent notes of this case. Master R— has remained under my care up to the present date (August, 1893). He has been improving the whole time, and it may be now recorded that his legs are quite well. He has been allowed to take exercise the whole time. The local applications have been varied. On several occasions I have cauterised sores which were especially unhealthy with the acid nitrate of mercury, and at one period he used at home as a daily application a strong solution of nitrate of silver. An ointment containing the bisulphate of mercury has, however, proved the most useful application, and it is under it



## PLATE CIII.

### BAZIN'S MALADY.—MULTIPLE ULCERS ON THE LEGS.

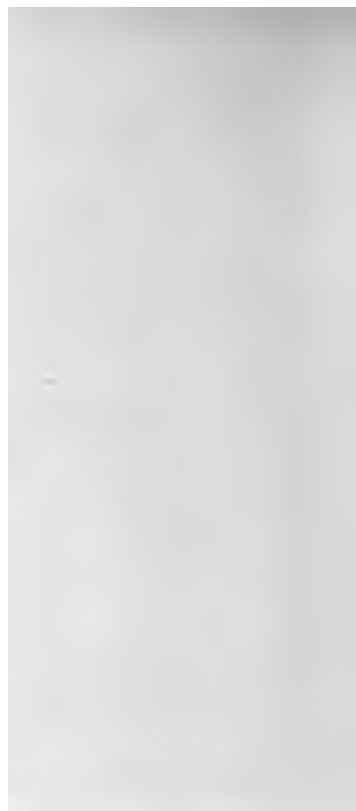


THE legs of Master R., Case XI., page 107, are here shown. It will be seen that there is slight general swelling, and that they are covered by scars and superficial ulcers. The latter are not well seen, being more or less covered by crust. The portrait was taken at a time when considerable improvement had been effected by treatment; but many of the ulcers still displayed, when the crusts were removed, irregular and somewhat undermined borders, and a surface destitute of granulations. The ankles and feet were wholly free, and so also, with very slight exceptions, were the parts above the knees. The portrait was taken about two years ago. At the present time all the sores are healed. Many of the scars are rather deep, and will be permanent.



1000







that the cure has at length been brought about. The legs are left covered with scars, some of them of large size.

CASE XII.—*Multiple Ulcers on the legs of an adult woman with a fifteen years' history—Recurring attacks of sore mouth.*

I saw the lady who is the subject of the following notes on January 17, 1890. Her case is remarkable on account of the long persistence of the disease. There was not the slightest reason to suspect syphilis. I am sorry that I cannot state anything as regards the result of my treatment, as I saw the case only once. Miss B——, aged 30, of healthy family, consulted me in January, 1890, on account of ulcers of the legs. She had previously been under Dr. T. F—— and Dr. L——. Her legs were covered with white scars from ulcers which began when she was 15 years old; and some of them had become thick and like a papillary keloid. After scarlet fever she once had an eruption of boils. Six years before that her mouth had become sore; and the same occurred two years ago. On the latter occasion there were blisters on the inside of the cheeks and under the tongue. Caustics had been applied both to the legs and to the mouth. Four years previously she suffered from anæmia, and was "as white as possible," but had quite recovered.

CASE XIII.—*Cutaneous indurations in the legs—No actual Ulcers—Debility and feeble circulation.*

Rev. F. G. P——, an unmarried man, aged 33, of a dark sallow complexion, consulted me on January 19, 1891. He was of Irish family, but had been brought up in Canada. In boyhood he had been delicate, and at the age of 18 he had had typhoid fever; and since then had enjoyed better health. Formerly he had been engaged in a bank, but for the last two years he had been a clergyman. The ailment for which he came to me consisted of large indurations in the skin of his lower extremities. (They were somewhat like those in the case of Miss R——, but with the difference that they had not broken down.) They were as large as pennies, and appeared to begin beneath the skin, but had adhered to it. They appeared dusky, and had often been expected to break down and to suppurate, but this had never happened. They used to desquamate and then slowly melt away, a dusky patch, almost a scar, being left after resolution. Mr. P—— had had them for eighteen months, but at first only one had been present at a time. Since September, 1890, the same swellings had persisted. In addition to the lumps, he had some quite local varicosities of his veins. Behind and above the left popliteal space was a large knotted lump of this nature. The lower part of his abdomen was crossed by large veins, and close to his umbilicus were some lumps—apparently thrombosed varices. The right leg, which was not so bad

as the left, had not been affected till the previous September. Mr. P—— said that he was liable to spots in the mouth, which came and went, and were probably herpes. His gums formerly used to bleed, but this had ceased. There was a single sore near his anus, which had ulcerated and showed an ashy base. It was perhaps ulcerated herpes.

The patient complained of feeling languid and weak, but had not recently lost flesh. These symptoms suggested diabetes. His urine was yellow in colour, and had a specific gravity of 1025. He was not passing it in excess, but had done so formerly. He did not suffer from thirst; and his bowels were regular. He had never had jaundice, but thought his liver was out of order. He used to have sick headaches.

On January 24th the urine was again of a specific gravity of 1024. The medicine had caused griping pain.

On February 10th he looked better. The anal ulcer had healed; but the indurations were still present.

On March 20th I saw him again. He had been to Hastings for a month, and had felt very well. He had been taking a mixture containing arsenic and nux vomica. The subcutaneous lumps were still present, and were of a red colour. His legs were slightly oedematous. The lumps near the navel had disappeared, but the veins were still very large (superior epigastrio).

*CASE XIV.—Gangrenous Ulcers on the legs of a robust adult man—Repeated relapses, with long intervals of health—No history of Syphilis—Insusceptibility to treatment—Cure by local use of Mercurial Ointment.*

The case of a man, named J——, seems worthy of record as an instance of ulcers on the leg, which had all the aspects of syphilis and yet were probably not of that nature. He was 49 years of age, a short, stout, florid man, who in his capacity as collector was constantly on his legs. He denied most positively having ever had syphilis, but admitted that all doctors had asked him the same question. He had been liable to ulcerations on his legs for many years; they had repeatedly got well, and then after a year or two others had formed. There had been an interval of complete soundness for five years before the attack for which he consulted me. Fifteen years ago my friend Mr. Cottle, after prolonged treatment, had cured the left leg, and it remained till this time quite sound, but with large scars. The type of ulceration was gangrenous, and at the same time infective. The inflammation spread subcutaneously from the first sore, producing a boggy spot at a little distance, which gave way and produced a fresh ulcer. [This was precisely the method of spreading which was observed in Miss ——'s case.] He was not liable to any other form of skin disease. When he came to me on September 2, 1891, he had on the front of his right leg a round ulcer with undermined edges, and in the middle a black slough of skin, still adherent, as

large as a shilling. The ulcer had been but little painful, and had been present only about five weeks. I examined the urine for sugar and found none. Both his testicles were in a state of chronic painless enlargement, but he said that they gave him no inconvenience and had been so for long. This condition induced me, in spite of his apparently clear and truthful denial of syphilis, to prescribe iodoform locally and the three iodides internally. After a fortnight under these measures the sore still remained, with a grey pultaceous base and slowly spreading edges. It was larger than before, and, though only in slight degree, was distinctly phagedanic. I now brushed it very freely over with the acid nitrate of mercury, and directed him to continue the treatment. On October 9th there was still some slough remaining from my caustic, and the edges of the sore were still not healthy. As the iodides and iodoform had now had a month's trial, I decided to change them, and gave him instead the solution of the bichloride of mercury in drachm doses, and an ointment containing half a drachm of calomel and two grains of bisulphuret of mercury to the ounce. A fortnight after this last prescription the change was most definite, the sore had contracted and showed healthy granulations in all parts. I may note, in passing, that during the early part of the treatment I had insisted on rest, but that during the last few weeks he had been walking about. He was so accustomed to constant exercise that he could not keep his circulation going without it, and remarked plaintively that his feet were always very cold on Sundays.

A fortnight after the last note I saw Mr. J—— again, and found the ulcer almost healed. There was, however, a certain amount of dusky oedema of skin at a little distance from it, which made him anxious lest it should form another sore. I have little doubt that the mercurial ointment was the real agent of cure, having often seen similar effects from it. I thought he had possibly been walking too much, and advised him to rest again.

A fortnight later still the leg was almost well. He was again walking about, and the ulcer not larger than a sixpence and quite healthy. Soon after this the sore healed soundly, and, so far as I know, it has remained well.

CASES XV. & XVI.—*Multiple Ulcers on the legs in association with Hydrops Articuli, and, probably, inheritance of both Gout and Scrofula.*

I may briefly refer to these two cases together, as they are closely similar. In each of them the patient, a lady of about 30 years of age, was the subject of a feeble circulation, with chronic arthritis and hydrops articuli, in one of them many joints being affected, and in each there were multiple ulcers on the legs. The case of Mrs. B——, aged 29, I have already recorded in ARCHIVES, Vol. IV. p. 67. I find that I have

omitted in that report to say anything as to the condition of her legs. She had suffered from multiple ulcers on the legs, four or five at a time, for the last ten years, and counted as many as sixty separate scars and ulcers.

In a second case, that of Mrs. H—, aged 84, the patient was a lady of very fair complexion, who had suffered much from chilblains. She had lost one eye after an iridectomy for recurring iritis, and she had been for five years past the subject of hydrops articuli of her right knee, with considerable thickening of the synovial membrane. During the last nine months she had multiple ulcers on her left leg. They were similar in character to those described in my other cases. There did not appear any reason to suspect syphilis, and she had four healthy children.

In both of these cases I have little doubt that the joint affection was the result of a partnership of scrofula and gout. In neither case can I state the result of treatment with certainty, but I believe that in both the ulcers on the legs were cured by the local use of the bisulphuret ointment.

CASE XVII.—*Case of Bazin's Malady, illustrating the condition some years after cure.*

I have recently seen a remarkable case, illustrating the condition of things after cure of this disease. My patient was a surgeon, aged 31, who had suffered from ulcerated legs for three or four years, from the age of thirteen to eighteen. He presented a pair of legs covered with scars, which on the front aspects were very large, but small and insignificant on the calves. They extended from his ankles to his knees; and he had none elsewhere. The scars were all quite sound, and had been so for many years. They were dusky and pigmented at their edges. Any one, not acquainted with the facts as regards Bazin's Malady, would certainly have taken them for syphilitic. This was the patient's own diagnosis, and, as he had never exposed himself to any risk of contracting syphilis, he suspected that they were due to hereditary taint. Of this, however, there was not the slightest evidence. He was a man of feeble circulation, and although he had never had any chest delicacy himself, several of his relatives had died of tuberculosis. At the time that his legs were ulcerated he was living in Canada. His impression was that they were always better in cold weather and worse in summer. He had never suffered from any form of sun-eruption on his face or hands. He did not know what the

special measures were under which the cure had been brought about, but he remembered that various ointments had been applied. (A portrait and photograph have been preserved.)

#### CONCLUDING REMARKS.

With this case I conclude what, for the present, I have to record as to Bazin's malady. It would not be difficult, by searching through note-books, to multiply cases. I am no believer in new diseases, and although it is only during recent years that this group of cases has been recognised as presenting peculiar features and deserving of a special name, I do not doubt that many have in former times passed under observation and received only an imperfect diagnosis. The question still remains, Is it worth while, or desirable, to construct this new group and to trouble the profession with a new name? I feel no hesitation at all as to this. The cases are peculiar, and they ought to be recognised. Correct diagnosis will greatly help as to their treatment, as well as save us from the risk of causing unhappiness by blundering imputations. If, however, any observer should attempt to define closely the limits of "Bazin's malady," to say precisely which are examples of it and which not—to treat it, in fact, as if it were in itself a morbid entity, he will, I think, make a mistake. After all is said, these ulcerated legs are only a phase of the protean disease Scrofula. Not till we obtain clear conceptions of what we imply under that name shall we be able to assign "Bazin's malady" to its proper place. Nor do I make apology to any one for the name which I venture to propose. We must have some easily remembered and brief designation for colloquial and literary use. Bazin was an observer well worthy of any honour which such use of his name can confer. The term which he himself employed, although, so far as it went, accurately descriptive—"Erythème induré des scrofuleux"—is at once incomplete (omitting the ulceration), and too long for familiar use.

For the many who find it difficult, from want of leisure, to master the detailed descriptions of cases, the matter may be epitomised thus:—"Bazin's malady" is a name given to a

manifestation of scrofula occurring mostly in young women, in which multiple ulcers, the consequences of a subcutaneous and self-infective inflammation, occur on the legs, such ulcers being difficult of cure, prone to relapse, and presenting appearances very likely to be mistaken for syphilis.

## ON JAUNDICE FROM SUPPRESSION.

THE phenomena of dry mouth—Xerostomia—have enabled us to appreciate the fact that it is possible for the functional activity of certain important glands to be entirely arrested under the influence of the nervous system. In most of the best marked examples of this malady which have been published, the condition has been permanent. The tongue, cheeks, lips, &c., remain absolutely dry under all conditions. It is a remarkable fact that the patient appears to suffer only inconvenience, there being no definite failure in health. Another noteworthy fact is that in almost all the cases hitherto recorded the patients have been women. We may, perhaps, derive some aid from what has been observed as regards this very remarkable symptom, in reference to the arrest of function of other glands, such, for instance, as the lachrymal glands, the glandular system of the stomach, the pancreas, liver, testes, and even the kidney. In all these it may be possible, under the influence of the nervous system, for permanent arrest of function to take place. In the instance of xerostomia, although brief arrests of function—the dry mouth of nervous excitement, for instance—are very common; and although in certain febrile diseases the tongue and mouth may be absolutely dry for weeks together, yet I do not know of any recorded example of what may be called “functional arrest” lasting a few weeks and then entirely passing off. As already stated, all the well-marked cases have been permanent or nearly so. In making this remark I am seeking for some parallel to what we know of functional arrests of the activity of the liver. In what is sometimes called, very inappropriately, “catarrhal jaundice,” it is not improbable that the essence of the disease is a complete temporary arrest

of secretion. The disease has nothing to do with catarrh, for its attacks are not produced by exposure to wet or cold. They are not liable as a rule to occur repeatedly, nor are they attended by any of the local signs of inflammation and local obstruction. That they are in some way connected with the nervous system is highly probable, and that they occur to those in whom there is an hereditary susceptibility may be taken as certain. In order to illustrate my topic I will briefly relate the particulars of a case. Although it is an example of what is very common, yet I think its citation may be useful in order that we may keep close to clinical facts.

A young lady of fair complexion and of nervous tendencies, but apparently in good health, was seized during the hottest of the recent hot weather with sickness and loss of appetite. She had no pain beyond a little sense of discomfort over the region of the liver, but she vomited everything that she swallowed, and could not retain even a few mouthfuls of water. Within twenty-four hours of the commencement of her sickness bile appeared in her urine, and on the next day her motions were the colour of pipe-clay. During the first three days no treatment beyond rest in bed was attempted. On the fourth day, as the eyes had become yellow and the vomiting still persisted, calomel in grain doses was given. From this date the sickness ceased, and the tongue, which had been much furred, cleaned; but the yellowness of the skin continued to increase for several days longer. There had not been at any time any material increase of temperature. The calomel was continued, in smaller doses and at longer intervals for about a week, and convalescence being then established the patient was allowed to get up. A week later, although still very yellow, she appeared to be quite well, and was as able to take long walks, &c., as before the illness.

In inquiring for a cause in the case which I have narrated, I was reminded by the patient's mother that I had once, some years ago, recognised jaundice in an elder sister, and that a younger sister was also liable to what were considered severe liver attacks, attended by sudden sickness, faintness, and sallow tint of skin. I was told also that a first cousin of



the patient, a girl about the same age living in New Zealand, had recently been laid up with an attack of jaundice.

We may take the above as a fair specimen of well-developed jaundice in connection with functional arrest. Bile was absent from the stools, and was present in the urine, and was abundantly deposited in the skin. The case, perhaps, does not quite prove that the liver had ceased to secrete, but it gives strong support to the suspicion that such was the case. There was not the slightest symptom of obstruction. Probably these cases of functional jaundice are only severe examples of the almost everyday occurrence of "liver attacks." Many patients are liable to attacks of biliousness during which the eyes become a little yellow, but in which the jaundice is never marked and the bile is never wholly absent from the motions nor obviously present in the urine. The difference is, however, probably only in degree. It is remarkable, however, that the amount of headache and general distress is not by any means always in ratio with the evidence of completeness of arrest of the liver function. Very severe sick-headaches may occur without demonstrable jaundice ; and what we may venture to call functional jaundice may be very well developed whilst the patient scarcely feels ill at all. As regards these differences, much probably depends on different degrees of nervous susceptibility in the patient. Many facts have been recently accumulated which suggest that we have entertained exaggerated notions as to the importance of the liver secretion in reference to health. On the one hand we have cases of biliary fistulæ, after operations, &c., in which the whole of the bile has been drained away externally, and never allowed to pass into the intestine, and in which yet the patient's process of assimilation did not appear to suffer ; and on the other we have cases of long continued mechanical obstruction without any rapid failure of health.

Attacks, more or less similar to the one which I have described, have, I believe, been very common during the recent hot summer. I have heard of them on all hands, and in those who were placed under most various circumstances. Two young men, brothers, total abstainers as regards stimulants, living in the same house, but engaged in different

occupations, have both of them been laid up at the same time with rather severe attacks of this form of jaundice. A medical man, whom I was treating for eczema, has also suffered from an attack. He had formerly lived in India, and might very possibly have some special proclivity to liver disorder. He referred his attack to "gastro-duodenal catarrh, which spread to the bile ducts and caused jaundice." As his attack was ushered in by diarrhoea, there is perhaps more plausibility in the method of development suggested than is usually the case. A common hypothesis, as regards what I would prefer to call functional jaundice, is that it is catarrhal, and that the catarrh begins in the duodenum, and in some way causes obstruction of the bile ducts. Plugging by mucus, for instance, is sometimes suggested. Not much that is plausible can probably be suggested in support of this hypothesis. Catarrhal inflammations are attended for the most part by excess of secretion; and not by obstructive swelling or inspissation of the discharges. It is very improbable that anything of the nature of mechanical obstruction by mucus is the cause of the attacks which we are considering. Nor do they obey the ordinary laws as regards catarrhal affections. In the latter it is usual for the patient to recognise the occasion on which he took cold. It is usual also for him to be liable to repeated attacks, at intervals, in connection with repeated exposure. Sensations of chilliness, and more or less tendency to shiver, are also the ordinary precursors of a catarrhal attack. These do not, however, usually occur in the beginning of jaundice, nor are those who have suffered from functional jaundice at all specially prone to have repeated attacks. I know many persons who enjoy good health, and do not consider themselves in any special degree "bilious," who have yet passed through single attacks of this affection. It is true there are a few who have had several attacks. A young medical friend tells me that he has had three, and that he is inclined to attribute them to anxiety or overwork.

I believe, however, that it is a matter of general experience that there are none who are liable to jaundice over and over again, with complete recovery between the attacks, after the

fashion in which so many are liable to severe catarrhal illnesses affecting the nose, throat, or chest. There are very many who are liable to recurring bilious attacks, during which probably more or less of liver suppression is present, but curiously this group of patients hardly ever get jaundice.

It would be of great value if some of the many intelligent observers engaged in family practice would carefully note their experience on these matters.

Respecting the pathological anatomy of this form of jaundice we are not likely to obtain many facts. Fatal cases do, however, occasionally come under notice. Death is usually preceded by cerebral symptoms. Even in the milder cases depression of spirits and general torpor of nervous functions are usually present. I find a report of a fatal case given by Dr. C. J. B. Aldis in some Clinical Reports published in 1835, which is of great value because it was followed by a post-mortem.\* It appears to have differed only from the case which I have ventured to record as a good typical example of the malady, in the severity of the symptoms and the cerebral complication. The patient was a girl of sixteen, who was admitted into St. George's Hospital, having been jaundiced for a fortnight. She had been in very low spirits, crying nearly every day; and complaining that her head was very confused. Her mouth was parched and dry, and she had a nasty taste in her mouth. She was still very sick, had very severe headache, and was drowsy. She was deeply jaundiced, and stated that she saw everything of a yellow colour. On the evening of her admission her torpor passed into insensibility. The next day she was comatose, and in this condition died in the afternoon. Excepting

\* We are not improbably liable here to the common fallacy that if a case is so severe as to end fatally, it is at once placed in another category. Acute yellow atrophy of the liver may, it is very possible, be the pathological anatomy of what is clinically functional arrest of liver action. If there be such a condition as arrest of function under nervous influence, analogous to xerostomia, nothing is more probable than that severe cases may now and then end in death, and that the affected organ may be found of reduced size and bile-stained.

The reader will find an excellent summary of present knowledge on this subject in Dr. Pye Smith's edition of "Fagge's Medicine." Several fatal cases from Dr. Bright and others are quoted.

intense bile-staining there was no disease of the viscera found at the post-mortem. The liver was soft, flaccid, and unusually small. Its substance was in parts stained with bile ; but there was no fluid bile in the ducts. The ductus communis was not obstructed, and was larger than usual. Dr. Aldis remarks, " There was nothing in the brain to account for the violent head-symptoms during life, which appear to have depended on the deranged state of the liver." He quotes from Mr. Twining's " Clinical Illustrations of Indian Disease " the following statement : " In some cases I have known robust patients die with symptoms of oppressed brain within thirty-six hours after the sudden appearance of intense jaundice ; for the accession of which last-named disease no cause could be assigned." That the coma in fatal cases of functional jaundice is due to blood-poisoning by the retained bile is made probable by what we know as to the mode of death in chronic jaundice. In a case, in which, a year or two ago, I was called in to do paracentesis in a case of long-continued jaundice with advanced cirrhosis of the liver, the mode of death was very peculiar. The patient, who was a robust man of about fifty-five, who had been a liberal champagne drinker, lay for three or four days in a condition of coma exactly resembling that of opium poisoning. It had set in rather suddenly, and some suspicion was entertained that a hypodermic injection of morphia had been administered by the nurse. Such, however, I feel sure, was not the case. The pupils, although small, were not extremely contracted, and to the last they reacted more or less on exposure. There was, as in opium-poisoning, a very remarkable retention of warmth in the extremities, although the pulse had almost ceased to be perceptible at the wrist.

The forms of liver disturbance, which are productive of the changes in the skin known as xanthoma, have scarcely received the amount of attention from physicians which they well deserve. They are probably by no means exactly the same in all cases, but we may probably suppose that in all they are due rather to functional inaction than to obstruction. It is not usual for any obstructive cause to be discovered at the autopsy in fatal cases, nor conversely do we observe anything

of the nature of xanthoma in cases of real obstruction. We seem, therefore, in the more ordinary forms of chronic xanthelasma to be dealing with long-continued functional disorder rather than with organic disease. That in the end organic disease, of the nature of cirrhosis, is in most cases developed is very probable. In some of these cases a very remarkable feature is the increased bulk of the liver and its proneness to temporary changes. In my papers on xanthelasma of the eyelids I have recorded several cases, in which the liver was liable to swell to such an extent as to become easily visible, filling a large part of the abdomen. In some of the most persistent cases of jaundice with xanthelasma, the tint of the skin becomes almost black, the patient still being able to persevere with his occupation. One or two illustrations of this will be found in the paper to which I have referred. That the form of liver disease, which leads to xanthelasma, is hereditary there can be no doubt, for the disease not unfrequently occurs in several relatives and in different generations.

In the forms of xanthelasma which are sometimes associated with diabetes—*Xanthelasma Diabeticorum*—although there is seldom any ordinary form of jaundice, there can yet be but little doubt that the liver is at fault. In these cases the patient will become covered very quickly with little papules or tubercles of a lemon-yellow tint, yet the skin itself is not bile-stained. Unlike the chronic and more ordinary forms of xanthelasma, these formations are capable of spontaneous disappearance, and usually vanish after a few months' duration. Although sugar is often found in the urine, this is not invariable. In one of the best characterised examples of the disease with which I am acquainted, the eruption being unusually plentiful, no sugar could ever be detected. The patient,\* although not jaundiced, considered himself very bilious, and both he and one of his relatives were liable to extremely severe headaches, attended with sickness. There can be little doubt that some functional

\* A good portrait of this man is preserved in the collection of the College of Surgeons and also in my own museum at Park Crescent. His case is published in *ARCHIVES*, Vol. I. p. 381.

disorder of the liver is the cause alike of the xanthelasma condition and of the sugar in the urine.

I must not dismiss the subject of functional disorders of the liver, leading as they do not infrequently to very severe derangements of general health and great diminution of aptitude for the pursuits of life, without saying a few words as to treatment. Certain principles in treatment are obvious to all. The avoidance of fatigue and worry, plenty of exercise and fresh air, and above all horse exercise, are recommendations which are easily given by the physician, but which it is often impossible for the patient adequately to follow out; nor will they, however well attended to, suffice, in cases in which the hereditary tendency is strong, to prevent the occurrence of attacks of liver disorder. We have, however, I believe, a drug at our command which, excepting under unusual conditions, will almost enable us to dispense with attention to these matters. If the patients, who are liable to liver disorders of the kind alluded to, will but take small doses of mercury for very long periods, they may, in ninety-nine cases out of a hundred, live like other people. A knowledge of this fact has come in connection with the modern use of small doses of mercury for the treatment of syphilis. In numberless cases patients, who had taken the drug for six months or a year, have declared themselves cured, not only of the syphilis, but of liver liabilities, which had previously very seriously interfered with the comfort of their lives. If mercury be given with the definite object of curing chronic liver disease and preventing sick headaches, &c., it should be prescribed in such doses that the patient does not feel it. It should neither purge nor salivate, and the patient, whilst under its influence, ought not as a rule to lose flesh. With these points in view the dose should of course be very small; but the course should be long-continued. The almost invariable result in properly selected cases will be, I believe, an improvement in the appetite, freedom from constipation and liability to headache, and a remarkable increase in nervous energy.

(See a postscript at p. 192.)

## MELANOSIS FROM MOLES.

(With Plate CIV.)

ALTHOUGH the occurrence of melanosis in connection with congenital moles has long ago been described, yet most lamentable instances of delay in recognition, and consequently in treatment, still occur. Three such have come under my observation during the last year, and they were almost the counterparts of each other. The cause of error lies in the fact that the mole itself rarely makes any material growth. It always grows a little (and this should be the note of warning); but it still remains so insignificant that only the well-trained observer is likely to take alarm. In one of the three cases referred to, the surgeon consulted ligatured a little fungating growth from the mole, and it fell off and healed soundly, leaving, however, the black base (see Portrait). In another the surgeon applied caustic; and in a third a prescription for black wash was given, because the mole had ulcerated. In all three cases the treatment adopted caused the mole to heal, and apparently brought about a local cure; but in all, the temporary stage of activity, or inflammation, had sufficed to liberate the germs of the new growth, and had produced numerous secondary ones. In no case did the mole itself ever much exceed the dimensions of a fourpenny-bit. I have already recorded the particulars of the case which my plate illustrates; the other two I will now briefly describe.

CASE II.—*Ulceration of a Congenital Mole rapidly followed by general diffusion of Melanotic Sarcoma.*

A lady, aged 31, emaciated and in rapidly failing health, came under my observation when covered with growths of melanotic sarcoma. Both mammary glands were affected,

and on various parts of the trunk and limbs there were subcutaneous growths of considerable thickness. There were very few in the skin itself, and none that were absolutely black. Probably, however, many of them were pigmented, for, showing through the thin, partially transparent skin, they produced exactly the greenish tinge which our forefathers knew as chloroma. The axillary glands on the side nearest to the mole were somewhat enlarged, but there was no extensive infiltration of the lymphatics. The patient suffered severely from pain in her back and on various parts, and it appeared not improbable that both lungs and liver were already implicated. The whole of what I have described had developed within the last six months in connection with a mole on the skin of the abdomen scarcely larger than a pea. It was exactly like that shown in the portrait. The mole had been present from birth, but not until about a year ago did it give the slightest trouble. It then became sore, and grew somewhat. A surgeon, who was consulted, instead of cutting it out, contented himself with making several applications of caustic, which caused it to heal. Soon after it had healed, however, the secondary growths began to show themselves. It must be noted, as an exceptional feature in this case, that the mammary glands became infected, and that the growths were, almost without exception, under the skin, and not in it.

CASE III.—*Ulceration of a Congenital Mole, followed by general Melanosis.*

I saw Mrs. H—— May 14th, 1893. She was a married woman, aged 38, from near Nottingham. She showed me in the sole of her foot a little black sore about as big as a sixpence, which was obviously a melanotic mole. It caused her little or no inconvenience in walking, and although superficially ulcerated, showed no tendency to fungate. She told me that the mole had been present most of her life, and that about two years ago it had begun to grow and had become sore. Her own surgeon in the country wished to cut it out, but she obtained the advice of a London consultant, who ordered her to apply some lotion, which soon made it heal, and from that time to the present it had given her little or no



inconvenience. She subsequently sent me this unfortunately successful prescription, which was for black wash. The sore having healed, she entirely refused to accept the advice to have the spot excised. A few months later, however, the glands enlarged in the lower part of Scarpa's triangle. These were excised by Mr. W——, of Nottingham, and the wound healed well. When Mrs. H. came to me I could detect up the leg and along the inner part of the thigh, as high as the saphenous opening, a great number of subcutaneous nodules, and at some parts fusiform thickening of lymphatic trunks. Near to the scar of the operation for removal of glands there were three or four newly-enlarged glands as big as nuts. There were a few little shot-like growths visible in the skin itself along the line of the lymphatics of the leg. Most of the indurations were, however, distinctly subcutaneous. The case was obviously too far advanced for any operation to be of use. This opinion was confirmed a few weeks later by a letter from her medical attendant, stating that a growth had developed on one shoulder. The case precisely illustrates the remarks which I made in ARCHIVES, Vol. II., pp. 202 and 349, respecting the usual method of development of melanosis in moles, and I may refer my readers to page 202 for a representation of the condition in which probably the patient was in in the present case. Nothing is more remarkable than the quiet and apparently insignificant character retained throughout by the original growth, which yet infects with great rapidity the lymphatic system of the limb itself, and finally the patient's blood.

It is surely quite needless to point out that the only proper treatment for an inflamed or irritated mole is immediate and free excision. On no account should any temporising measures be permitted. The patient's only chance of safety consists in excision of the whole thickness of skin with a very wide margin. It is much to be desired that all members of the profession should have their minds fully alive to the features presented by these cases and the terrible results of loss of time. It is in the hope of impressing this lesson that I have thought it worth while to publish the portrait.

The following case may be quoted as one in which the local growth was large. It would appear that the tendency to local growth is in inverse proportion to that of infection of the system.

CASE IV.—*Melanosis taking its origin from a Mole—Large fungating growth.*

Mr. O——, aged 51, was sent to me on June 9, 1892. Ten months previously a mole, which he had long had on his abdomen, commenced to grow, and at the time of his visit there was a large fungating mass in the middle of the abdomen, with little shot-like growths of melanosis near it, and others which were not coloured. There were present many little moles of various size and character. The glands in both groins were hard, and the lymphatics down the thighs were tender.

Dr. E—— subsequently reported to me that the cancer grew rapidly, and became a very large, offensive mass. The poor fellow, under his sufferings, became the subject of delusions, and, being violent and suicidal, had to be placed in an asylum. He was relieved by death on December 12th.

CASE V.—*Large Local Melanotic Growth from a Mole.*

I may just mention a fifth case, which differs only from the three preceding in that there is as yet no proof of constitutional infection. In it I excised from the back of a man, aged about 60, a very large elliptical portion of skin which was involved in melanosis from a growing mole. The mole had grown from the size of a sixpence to that of a child's hand, but there was no proof of any infection of the system. The wound has for the present healed; but, as the mole had entered upon its sarcomatous stage at least a year before the operation was done, I am much afraid that before long I shall hear of recurrence in the viscera.



## PLATE CIV.

### MELANOSIS IN A MOLE, WITH SECONDARY GLAND DISEASE.



On the right side of the abdomen is seen a little black patch. At the site of this patch there had been a congenital mole. During the year preceding the sketch, this mole had grown and produced a little, fungating excrescence, which a surgeon removed by ligature. The wound healed, but the base of the sore remained black, and shortly afterwards the glands below the axilla began to enlarge. When I was consulted, not only was there a mass in the armpit, but a long chain of indurated glands extended up the neck, under the sterno-mastoid. Any further operation was clearly impracticable. The man died with an enormous gland mass, and with indications of internal visceral disease, within about a year of the time when his mole first began to fungate. The case affords the clearest possible proof of the necessity for free and early excision of all moles which show any tendency to take on growth.











## THE TREATMENT OF STRANGULATED HERNIA.

THE results of operations for strangulated hernia, at the present day, present some questions which ought to receive our most careful consideration. It would appear, not only that the advance in what is called abdominal surgery has in this department achieved no triumphs, but that our art has positively gone backward. I will endeavour to state as fairly as I can the changes which have taken place in opinions and results within my own experience. In the first place we have to note, during the last half-century, the growth of a very decided distrust of attempts at reduction by taxis, and a preference for immediate operations. This is very emphatic indeed in the teaching of our schools. A student is now scarcely instructed in the details of the taxis, and is warned that if he attempts it at all it must be in the very gentlest manner, and only for a very short time. During the later years of my examinership at the College of Surgeons, I was often amused to see that a student would treat a question as to the details of taxis as if he thought it were a sort of trap for him, and would reply at once that he would use it only for a minute or two, as gently as possible, and then proceed to the operation. Nor does this timidity, I believe, in the least exaggerate the precepts of some of our leading surgeons. I have been assured by several, whom I have asked as to their proportion of successes by taxis, that they scarcely ever attempt it, but prefer to operate at once. In this we have, indeed, a most remarkable change from the opinions which were prevalent in former days. When I was a student in the city of York, there was a surgeon living there who had the reputation of being able to reduce all hernias. He was a man of short stature, powerful frame, and very strong hands. He

was not popular in the city, and especially not so amongst the profession; but his boast was, and I believe it was to a large extent supported by facts, that, when a patient had a rupture which his medical attendant could not get back, there was generally a demand that Mr. Hopps should be called in. There was a tradition that he used sometimes to kneel upon them; but this, I believe, was scandal. That he was remarkably successful I have no doubt whatever. In those days we did not know that death might occur after reduction by taxis, and our belief was that a success with the fingers was a triumph without a drawback, saving the patient from a very perilous operation. When, on leaving York, I came up to St. Bartholomew's Hospital, I was there taught by Mr. Wormald that it was practicable to succeed by the taxis in a majority of cases. Mr. Wormald was a man, like my York teacher, of good muscular development, and with large powerful hands. He told me, what I had in part learnt before, that it was exceedingly important in the different forms of hernia to keep accurately in mind the direction in which the reduction had to take place, to use the left hand for steadying the neck of the sac and the right for compression. I was taught also even to try to make the neck of the sac slip downwards at the same time that I compressed the hernia. In particular Mr. Wormald insisted that all *inguinal* herniæ might be reduced by taxis; and I well remember his chagrin when, on one such, he was unable to succeed and was obliged to operate. I believe it was the first case in which he had used the knife for inguinal hernia, and he had then been assistant-surgeon to St. Bartholomew's Hospital for some years. There was a joke against Mr. Stanley, another highly valued teacher of mine, that he had refused to let Mr. Wormald examine a hernia, on which he was about to operate, being afraid that it might be reduced. The line of practice which reached its acme in such men as Mr. Hopps in York and Mr. Wormald in London was by no means peculiar to them, but was attempted, though with less success and in some instances with less zeal, by all the surgeons of that day. Every one reduced by the taxis as many as he could, and a great variety of what were called "adjuvants to the taxis" were in common use. Amongst

these, the hot bath, pushed to faintness, and the application of ice to the tumour were the chief ; but alterations in the position of the patient's body and even shaking the body in the inverted position were occasionally resorted to. When chloroform came into general use, and it was found that by its aid not only might the patient be saved all pain during the manipulations, but that the abdominal muscles might be placed in a condition of absolute inaction, great hopes were entertained that the taxis would prove more frequently successful than ever. The medical journals of the day teemed with narratives of successful reductions under chloroform. At a later period, the use of the ether spray over the tumour itself, as an improvement on the ice-bag, received the warm commendations of many. I believe that there are some surgeons of the present day who would shudder at the bare idea of putting ice on a hernial tumour.

About the year 1840, Mr. Luke took up warmly the advocacy of Petit's operation, which he regarded as a sort of half-way between the taxis and a complete herniotomy. As is well known, it avoided opening the peritoneum. All the surgeons at the London Hospital and many at others followed Mr. Luke's practice. It was believed that here again a very important advance had been made, and in Druitt's "*Vade Mecum of Surgery*" (1847) I find it stated that Mr. Luke's ratio of fatality after hernia operations by the new method had been reduced to two in forty. It is right that I should add that I cannot help feeling some doubt as to whether this statistical statement is well-founded; but I do not recollect ever to have seen it contradicted. The surgeons of St. George's Hospital from the first, and almost in a phalanx, refused to follow the fashion as regards not opening the sac, and they were able at a subsequent period to show by a comparison of statistics with those of the London Hospital that the gross results of the two methods did not differ much. It is to be remembered that these statistics were obtained at a time when attempts at taxis were persevered in far more than they are at present, and when consequently only a residuum of the worst cases were submitted to the knife.

I may perhaps be pardoned if I now state my general im-

pressions as to my personal practice. The London Hospital has probably for long had the largest practice in strangulated hernia of any institution in London, perhaps in the world. It is in the centre of a densely populated district inhabited by working people. St. Bartholomew's and Guy's probably come very near to it, and at these three institutions operations for strangulated hernia average from twenty to thirty a year, or about one every fortnight. When I was elected on the staff of the London Hospital in the year 1859, I was, as may be supposed from what I have said as to my teachers, although very fond of operating, a zealous manipulator, and one who took pride in success by the taxis. Especially I used to take the utmost pains with inguinal herniæ, and I may here say that I have never, either in my own practice or in that of any other surgeon, known of any case of death after a satisfactory reduction by taxis of an inguinal hernia. From this statement, of course I except all cases of incomplete reductions, cases in which the bowel is pushed between the layers of muscles and cases of *reductio en masse*. In all these the symptoms persist and an immediate operation ought to follow. What I mean is that I have never known a case, in which the intestine had slipped fully and freely into the peritoneal cavity, do otherwise than well. I cannot make this statement as regards femoral hernia, for I have known three or four cases in which, after complete reduction, the patient yet died of peritonitis.

I was on active duty, as one of the staff of the London Hospital, for twenty-four years, and, during most of this period, from a fourth to a third of the hernia cases admitted into the wards would fall to my share. During part of this time one of my colleagues, who early adopted the principle of preference for operation over taxis, used to operate, I believe, on nearly twice as many cases as I did. I was once told that my house-surgeons said that it was no use sending for me to a hernia operation, because I always spoilt the case; and I have little doubt that this belief induced them to take much more pains with the taxis before sending for me than would otherwise have been the case. My rule was always to try the taxis patiently, if there were no indications

that the bowel was already in a bad condition. If either the general state of the patient or the local condition of the tumour seemed to imply the latter, then I always operated at once and always opened the sac. If the case seemed one to justify an attempt at taxis, then I always held that it was one in which, if practicable, it was best not to open the sac. It seemed clear that in all cases in which, on inspection of the gut, it was thought well to return it into the abdominal cavity, it would have been still better to have reduced it without exposure. Only the cases in which the surgeon deems it his duty to leave the gut in the sac (or to excise it, according to modern practice) are those in which success by taxis would not have been an advantage. As regards the amount of force in applying the taxis, I can only say that I used all that my hands possessed, and that I often wished that they were stronger and did not tire so soon. In inguinal herniæ I have, when my hands were tired, asked one of my colleagues or my house-surgeon, or even both, to take a turn; and more than once I recollect Mr. Louis Little or Mr. Waren Tay having succeeded after I had failed to do so. One remarkable case is imprinted on my memory of an inguinal hernia in an adult man, in whom, under an anæsthetic and in the operating theatre, Mr. Tay and myself had tired our hands in repeated attempts; and as a last resource, just before proceeding to the knife, I asked my house-surgeon to do his best, and he succeeded.

I may here say that I have never been guilty of delay in operating for strangulated hernia, unless the time taken up by the taxis be considered such. Only in exceptional cases, in which the strangulation was ill marked, have I ventured on any prolonged use of ice. The hot bath had usually, as a matter of routine, been tried by the house-surgeon before I saw the patient. As years went on I felt more and more confidence in anæsthetics as superseding all other adjuvants of the taxis. Almost invariably the patient's assent to an operation was obtained before the anæsthetic was used, and, if the hands failed, the knife was forthwith employed. There is a great difference between patient efforts at the taxis and delayal of the operation. I am very in-

credulous as regards the harm done by careful though very forcible manipulation. The bowel is as a rule well protected, not only by fluid in the sac, but by a layer of fat over it; and it is not possible by any ordinary force to damage it by bruising. The appearances which are so frequently attributed to bruising, are really, I hold, the consequences of the stricture. I have seen the soft parts ecchymosed as a result of bruising, but I never saw anything in the gut itself which I thought attributable to the manipulations. Of such an occurrence as rupture of the intestine I have had no experience whatever. In a case in which I operated only a few weeks ago, there was a considerable extravasation of blood external to the sac, which looked formidable enough when the incision was made, and which was, I have no doubt, due to forcible manipulation. The patient was elderly, with diseased vessels. I did not open the sac, and so cannot report as to the state of its contents, but the ecchymosed parts healed without a trace of suppuration, and there was no drawback to the patient's rapid recovery.

It is not in my power to give anything approaching to full statistics of my ratio of success by taxis and herniotomy respectively as compared with that of my colleagues; nor would it be graceful to attempt it. I may say, however, that several of my colleagues—Mr. Luke, Mr. John Adams, Mr. Curling, Mr. Nathaniel Ward, and others—adopted the same rules as regards patient trial of the taxis, and the use of all suitable adjuvants, that I did. I may, however, just mention that for the year 1875 the Registrar credits me with having had no operations for hernia at all, although my average share ought to have been eight.

It may be suitable, perhaps, that I should record my experience as regards the supposed difference between hernia cases seen in private and those in hospital. It is customary to say that the hospital cases are a much less hopeful series than those seen in private. My impression is that the reverse is the truth. When I lived in Finsbury Circus I had a large experience of hernia operations in private at the East End of London. It was the day of small fees and many patients, and it ended when I changed my resi-

dence. When a case of strangulated hernia occurs to a poor person, in many instances the patient goes straight to the hospital. In many others the surgeon who is first consulted does not choose to accept any responsibility in the case, and immediately sends it there. Amongst patients able to pay for advice, it is well known that if a consultant is called in a fee will have to be paid, and thus but too often the family practitioner is encouraged to persevere unaided, until the symptoms become so severe as obviously to admit of no delay. The average duration of strangulation in the cases to which I have been called in private, has I believe been much longer than in hospital cases. I have met with gangrenous intestine more frequently in private than at the hospital, and the opportunities for really early operation occur I believe far more frequently at hospitals than they do to consulting surgeons in private. This impression is confirmed by what I observe stated as to the duration of strangulation in some of our hospital reports. Thus in those of St. George's I find it repeatedly recorded that the operation was done within six hours of the time of strangulation. I do not think that I ever in my life saw a case in private practice in which the duration had been so short.

These remarks obviously apply to cases as seen by consultants, and not to those under family practitioners. In private the latter intervene and often succeed; whilst in the cases to which we are called in the hospital very often they have had no share, and the patient is under the care of the operator almost from the beginning.

*(To be continued.)*

## MUSEUM NOTES.

THE following notes concern specimens which have claimed my interest at different museums during the present summer. They are chiefly from the Musée Dupuytren at Paris, and where I have used the initials M. D. it is this collection which is intended.

### *An Endemic Pigment Disease (Gomez' malady).*

In the Musée Dupuytren are ten oil-paintings illustrating different stages and forms of a pigmentary disease of the skin called Carather or "Taches endemiques des Cordilleras." One is the espèce grise and another the espèce bleue.

Reference is made to a Thesis by M. Josne Gomez, published in 1879. I did my best, but without success, to obtain this essay. The portraits are of patients whose cases are there published.

All the portraits are those of men. They show deposit of pigment in large very ill-defined blotches on face and limbs. In some absorption has been in progress and leucodermic areas have been left.

I am not aware that this disease has as yet been noticed in English literature, and it therefore seems worth while to draw attention to it. So far as an inspection of the portraits themselves will go, a suspicion might be entertained that the disease is an example of what is known both in Vienna and in Paris as Leucoderma Syphiliticum, a pigmentary form of secondary syphilis. There is nothing improbable in the supposition that in tropical climates the tendency to pigmentation in a syphilitic exanthem may be much more likely to occur than it is with us. In England we but rarely see anything approaching the characters of leucoderma in association with



syphilis. I must throw out this suggestion with much diffidence, since I have not read the author's description of his portraits. The thanks of the profession are due to him for procuring, probably under circumstances of difficulty, such good pictorial illustrations.

*The Diffuse Lipoma of Beer-drinkers.*

I have never seen in Paris, either in the streets or in hospitals, any examples of the diffuse lipoma of the neck, &c. In the M. D., however, there are two models representing this disease. One of them shows the largest masses which I have ever seen. The man's head projects out of a mountain of fat. It beats utterly the portrait which Mr. Swainson did for me and which was, at the time, the largest I had ever seen. This model is No. 87, but no one seeking it can miss it. By its side No. 87A, which represents the same disease, might be taken for a normal condition.

*Osteitis Deformans.*

No. 333, in the D. M. is a collection of bones showing "Hyperostose général de la tête, de la column vertebrale, des côtes, du sacrum et de l'os iliac. Homme de 70 ans." M. Rullier.

The bones are splendid examples of Osteitis deformans.

No. 375. Hypertrophic thickening of the frontal bone, &c., in a child. Anterior fontanelle still open. This preparation offers a very remarkable simulation of Osteitis deformans from a child. It is labelled "Hyperostosis des os de la voute du crâne chez un enfant de 18 mois." I took it at first sight for the top of an adult skull with osteitis deformans, but on observing more carefully I saw that only the bones of the anterior half are involved and that there is a hole through it at the position of the anterior fontanelle. The thickness of the frontal bone where cut can scarcely be less than half an inch. There are no traces of inflammation.

*Specimens of Rickets.*

The specimens of rickets in the Dupuytren Museum are very numerous and good. They show over and over again that

in the form of the disease in which the bones bend there is no arrest of the growth in length nor any evidence of overgrowth at the epiphyses. There are long, slender bones bent into most various shapes. Thus it is certain that although rickety persons may lose in stature they do not do so from want of growth of the limb-bones. It is further certain that there is a form of intra-uterine rickets in which the bones bend but show no thickening at any part nor any defect as to length. Specimens 513 and 514 ought to be photographed side by side. Both show the skeleton of a foetus. In one the bones are shapely and long, but those of the lower limbs much bent, whilst in the other all the conditions of the thick-boned, short-limbed dwarf, as seen in the Norwich skeleton are reproduced. It is clear, then, that, if the latter be rickets at all, there are two forms of that disease during intra-uterine life, one attended by arrest of growth of long bones, and the other not. These two specimens are described as follows: 513, "*Squelette de foetus dont les membres inferieurs sont atteints de rachitisme congenitale. M. Skellage.*" In this the bones of the lower extremities, of good length and not thickened, are much bent in diverse directions, probably by intra-uterine pressure. Owing to loss of height from the bending of the femora, the fingers touch the knees. None of the epiphyses are altered in shape.

514 is a fac-simile of the Norwich dwarf, making allowance for age. All the long bones are very short and thick. They are not in the least bent, but yet the finger-tips scarcely touch the iliac crests. The epiphysal ends are very large. The specimen is somewhat erroneously described as "*Enfant a terme dont les os presentent les courbures rachitiques avec une hypertrophie des os qui peut être considerée comme une re-ossification.*" There is not the slightest trace of courbures; indeed they are too short to be curved.

514b is figured in Hoel's Atlas to Catalogue as a short-limbed dwarf. "*Foetus dont les os presentent une ossification premature avec des courbures anormales.*"

514c (not dissected) is another specimen of a short-limbed foetus, and it, with 514a, might be claimed as intra-uterine rickets. Both are described as such. In neither, however,

is there any bending. The conditions are arrest of growth in length with great general thickening. In both cases the finger-tips just touch the iliac crests. 514A is partially dissected and the state of the fœtus is represented by a plaster cast.

*The Skeletons of Dwarfs.*

331B is the skeleton of an adult dwarf. It is the counterpart of the Norwich skeleton, but has in addition an extreme lateral curvature of spine which very greatly reduces the height of the trunk. It is labelled "Squelette atteint de deviations rachitique, les membres superieurs et inferieurs sont frappe d'arret de developpement." Thus it will be observed that both "rickets" and "arrest of development" are assigned as causes. The question is Which? I cannot discover any trace of rickets, unless the enlarged epiphyses be assumed to be such. This would, however, be to take for granted what is not proven. Undoubtedly all these short-limbed dwarfs show it, and disease of the epiphyses was probably a cause of the arrest of growth. Has this epiphysal abnormality, however, anything in common with ordinary rickets? In this skeleton all the long bones are very short and their ends clumsy and thick. Their shafts are well rounded and smooth, especially those of the bones of the lower limbs. The humeri are thick and show strong ridges like those of the Norwich specimen. Not a single bone shows any curve, nor are the ribs or the pelvic bones altered. The pelvis is small but broad (a woman?). The altered shape of the femoral necks twists the bones so that the knees look outwards and the feet have their soles towards each other. The feet have very high arches and the heels are drawn up—they were probably "clubbed." The sternal ends of the clavicles appear to be somewhat sloped but not so much as in the Norwich specimen. If the spine were straight the tips of the fingers would only just touch the iliac crests. The head and teeth are well formed.

There are short-limbed dwarfs in which the shortness of limb is extreme and is due to entire absence of some of the bones. Without feeling at all certain on the subject, I yet do not see

any definite reason for declining to recognise these as resulting from a yet more severe failure of the same kind as that which causes shortness of the long bones. It is precisely the same bones which are defective. In both groups of cases the hands and feet are fairly well developed, whilst the femur, tibia and fibula, the humerus, radius and ulna are the bones which are shortened in the one group and almost wholly absent in the other.

*Illustrations of Absence of the Principal Bones of the Limbs.*

The best examples of the partial absence of the long limb-bones which I know of are to be found in the Musée Dupuytren. 29 and 30 in this museum probably belong to the same man, although it is not so stated. They are almost exactly alike. 30 (the cast) is described as "Modele en plâtre du nomme Pepin, dont le tronc est bien conformé, mais les membres thoraciques et abdominaux sauf les mains et les pieds, ne sont pas developés." 29 (the skeleton) is described as "Squelette d'un homme mort à Bicêtre, à l'âge de 62. Les membres thoraciques et abdominaux sont imparfaits."

I will describe the skeleton, and may say that the plaster cast presents nothing inconsistent with the supposition that it represents the same individual during life.

The hands are perfect, and so too are the feet with the exception that the arches are very high and the insteps correspondingly short.

To each foot is attached a short portion of the tibia without any trace of fibula. The tibia ends in an obtuse point about three inches above the ankle, and of the bones of the knee or shaft of femur there is no trace until we come to the base of the lesser trochanter; above this level the neck, great trochanter and head of femur, are of natural form and size. The femur ends abruptly, as if it had been broken transversely and the lines of fracture rounded off. There is no deformation of the femoral epiphysis. The limbs being shortened the feet are placed across what should have been the top of the thigh and the fragment of the tibia passes in front of the neck of femur and almost touches the lower anterior spine of ilium. On the right side it appears to have

actually touched, for a flattened surface is seen, due probably to its attrition. On the left there is a connecting ligament.

The hands, as I have said, are well formed and of normal size, and they possess, so far as I could see, the proper number of carpal bones, but of radius ulna or humerus there is no trace. The shoulder bones are well-formed, coracoid, acromion, and clavicle, but the glenoid cavity on each side is filled and presents instead of a hollow a rounded projection of bone.

The ribs, thorax, vertebræ, and pelvis are well formed, but the bones of the latter are small and light for a man (partial disuse).

No 28 is a fœtus which almost repeats the extraordinary conditions of 29 and 30. It has well-formed hands and feet, but they are attached, like fins, to the trunk without intervening bones. The feet are turned towards each other so that their soles touch. It is described as "Fœtus d'environ 7 mois qui présente un grand nombre des plis verticaux de la peau, qui est en excès." The skin hangs loosely like a bed-gown on the short, almost limbless, fœtus. Another example of the same condition is presented in No. 31, with the important difference, however, that only the upper extremities are affected. In this specimen the hands rest within an inch or two of the shoulder joints. The hands themselves are small but well formed. It is a full-grown fœtus. The lower limbs present no peculiarity. It is described as "Fœtus phocomele, les membres thoraciques manquent et les mains paroissent s'interer au tronc." An incision has been made into the soft parts in front of one shoulder, and so far as can be distinguished the pectoral muscles are present. In the plaster cast, 29, they appear to be absent.

We have in specimen 45 an example of abortive limbs in a puppy. The four limbs hang like small fins on a dumpy, rounded body. They are defectively developed. The head and face are much malformed and the brain probably absent. It is therefore an example of failure of development of the limbs in association with extreme defect of the nervous centres. It is not dissected.

*(To be continued.)*

## ECZEMA AND HOT WEATHER.

THE hot weather of the past summer has been productive of a great many cases of the diffuse eczema which so often affects the aged. The epidemics which occurred in the Workhouses, to which I have repeatedly referred, have helped us to a clearer recognition of the influence of summer in producing these attacks. As a rule, in the sporadic cases, the attack is not absolutely a novelty to the patient. Almost always there is the history that there has been for long a quiet, chronic patch of eczema on the leg, behind the ear, on the scalp or somewhere, which, under the influence of the summer weather, has been exacerbated and shown a tendency to spread over the whole surface. I do not think that much can be said as to the influence of gouty conditions, or of diet, in exciting these outbreaks of dermatitis. They happen to all sorts of people, and the fact that epidemics have occurred in workhouses is in itself an almost conclusive answer to the suggestion that they are connected with gout. My impression is that heat, and the perspiration that attends it, are the main factors. It is quite clear that in some way a self-infective material is generated, which has the power of causing the dermatitis that attends its evolution to spread, more or less rapidly and widely, from its focus of origin. I have already asked attention to the features in which this dermatitis resembles a mild form of erysipelas, and have ventured to advance the hypothesis that there are cases in which it is really a hybrid between erysipelas and eczema. I do not purpose to trouble my readers on the present occasion with any further discussion on these points; but it may be of interest to narrate briefly a few cases which illustrate them. The first which I shall mention is the last

that I have seen, an old gentleman, who has come under my observation on the morning of my writing this. He bore the most emphatic testimony to the influence of hot weather in aggravating his eczema.

*Pruriginous Eczema of twenty years' duration—Always worse in summer.*

Mr. A——, aged 68, a stout and very healthy farmer, “an abstainer, but not pledged,” has been the subject of eczema for twenty years or more. By his own avowal he has been a good scratcher for at least thirty. His father, he says, suffered in the same way. He is, at the present time, covered with pruriginous papules and large ill-defined patches of eczema. The eczema is best developed on the nape of his neck and his scalp; but it is well characterised on other parts also. Mr. A——’s testimony is that his skin is always very irritable in summer weather, and that it gets almost well in the cold of winter. Although he has suffered so long, he has never until the present occasion sought medical advice. He excuses this negligence by saying that his father never got cured, but there is no doubt that, in consequence of the prolonged summer, his condition is now far worse than ever before. It now quite destroys his rest at night. I prescribed for him a tar wash, a tar ointment and a mixture containing tartar emetic.

This case as nearly approached the type known as “Hebra’s prurigo” as any which I have seen for years. It was, however, distinctly a lichen-eczema, and instead of beginning in childhood it did not commence until middle life.

It will be seen that this case differs somewhat from those to which I have alluded above, in that there has been no sudden outbreak of an infective inflammation of the skin. There has been nothing at all approaching to erysipelatous swelling in the case. Two or three of those which I am about to relate are examples of very sudden and severe outbreaks, attended with vesication and great oedema of the skin. These cases are too acute to be attended by prurigo. It may be remarked that in proportion to the acuteness and suddenness of their development is usually the ease with which

they are arrested. The reader will note that in some of these cases the patient had experienced a precisely similar attack some years before. The question arises, in reference to this class of cases, as to whether there is any truly catarrhal element of causation in them.

*Liability to attacks of an Acute Vesicating Eruption in the face and hands—Senility—Influence of sunny weather.*

Mrs. G—— consulted me a second time for a very severe relapse, in April, 1893. She told me that, during the five years which had intervened, she had experienced no serious attack. On several occasions, and chiefly, she thought, in spring weather, she had been threatened; but had always resorted to the remedies which I had prescribed, and nothing had ever developed. At Christmas, 1892, however, her face was again attacked, and, although she managed to ward it off for a time, at Easter, during days of hot sun and east wind, it blazed up with great severity. Her face swelled so that it closed her eyelids, and, in spite of all treatment, the attack persisted, until a month later she came up to town and called on me. She said that she had no doubt that the attack had been produced by working in the garden during the spring weather. Her face and neck were still covered with scaly desquamation, and the skin was swollen and congested. The prolabia were cracked, and there were fissures at the corners of the mouth. The hands also were in a condition of diffuse congestion with desquamation. The attack had been strictly limited to the face, neck, and hands. She had been feverish and ill during its height, but had regained her usual health when I saw her. She was now 74 years of age. Her case was in all respects exactly like that of the boy Bennett (see page 144).

*Liability to attacks of a Vesicating Eruption on the face and hands.*

A Mrs. D——, aged 52, who was sent to me, April 17, 1893, by Mr. Bevan, of the Commercial Road, affords a very close parallel to the preceding (Mrs. G——) and other cases. She came to me with her face and neck red and desquama-



ting. Her hands were in a similar condition, though less severely affected. She said that the attack had commenced six weeks before, and that it had begun on her neck, apparently from the irritation of her frilled collar. It had been very severe, and for a time had closed her eyelids. After it had involved the whole of her face, the hands were attacked. It had not extended lower on her chest than her clavicles, nor on her forearms much higher than her wrists. It will be seen that this attack began, like Mrs. G——'s, during hot spring weather, and that the two commenced almost at the same time. In Mrs. D——, however, there was no history of any special exposure to sun. In connection with this matter, however, the following fact is of great interest. Mrs. D—— told me that she had suffered twelve years before from a very severe attack of eezematous dermatitis, which was confined to her hands. She had been out all day in a boat in the hot sun, and, to use her own expression, on the following day her fingers were covered with little blisters, "as if I had tipped a kettle of boiling water over my hands." On this occasion her face did not suffer, but the inflammation of her hands lasted six weeks. She never afterwards had a severe attack until the present one, but on several occasions had had slight threatenings.

*Acute attacks of a Vesicating and Bullous Eruption on the face and hands in an elderly woman.*

I had seen this lady in consultation with Dr. S—— for a very severe outbreak of erysipelas-eczema on her face and forearms about three years before our recent consultation. I then prescribed an antimonial mixture and lead lotion. I saw her but once. The second consultation was for an attack of precisely the same kind, but yet more severe. Her forearms were covered, not only with vesicles, but with large vesications, as if they had been scalded. These vesications were totally different from the bullæ of pemphigus, being produced by the coalition of adjacent vesicles, and being very irregular in form. Mrs. M—— told me that what I had prescribed on the former occasion had cured her quickly, and that, with some slight exceptions of threatened relapse, she had

remained perfectly well ever since. She was a stout, well-preserved old lady, accustomed to live rather freely, and of gouty tendencies. She thought that the present attack had been produced by an unexpected exposure to cold air in her passage, but about this there might be much doubt. I had only to recommend a more persevering use of the same remedies, and I believe they were again soon successful.

*Erysipelatoid Eczema of face and hands from exposure—Repeated attacks in a healthy boy.*

[Continuation of case of Master Bennett, whose portrait is kept at College of Surgeons.]

I did not see this boy again until three years after my last note. He was then brought to me suffering from another very severe attack. Both hands and his face were covered with a bullous, eczematous eruption. The bullæ were formed by the coalescence of a number of vesicles. By the sides of his fingers many of them were ruptured, leaving abrasions: The eruption, although most severe upon his hands and face, was not absolutely confined to these parts. There were some vesicles on his chest and a few on the abdomen. They were, for the most part, discrete; but here and there arranged in groups. I was told that the present eruption had been threatening for about ten days, but that it had developed suddenly in its present severity, apparently in consequence of a long ride on his bicycle on the previous day. The boy did not appear to be particularly ill, and what little disturbance of health was present was probably entirely due to the irritation of the dermatitis. I was told that during the three years that had intervened since his last attack, he had been almost wholly free; at any rate he had had no severe outbreak. Occasionally a few spots had threatened, and his mother had thought it necessary to give him the medicine which I had prescribed, and to which she attributed his cure. This medicine consisted of an antimonial mixture containing a sixteenth of a grain to the dose. His mother thought that the threatenings of relapse had usually been in the spring, and it is to be noted that we have recently had unusually

warm weather for the season, followed by cold and east winds. I suggested that the inflammation of his hands and face was probably due to the irritation of sun and wind during his bicycle ride; but I was assured that he had worn gloves. It is a point not to be forgotten that he is a boy of a very fair, delicate skin, and that his face is freckled in a most unusual degree. In the intervals of his attacks his skin had been perfectly well. Thus the disease showed no tendency whatever to lapse into chronic eczema. It seems probable that the case should rank as one of a congenital susceptibility of skin, and not as a catarrhal disease. I was in the first instance somewhat inclined to the latter diagnosis; but that the attack on the present occasion has been induced by exposure to wind and sun is, I think, tolerably certain. It is not an ordinary "summer eruption," for it does not persist during the whole of summer, nor is it worse in the hottest weather.

*Pityriasis Rubrum, or Eczema Universale?*

Mr. —, æt. 60, February, 1887. It is desquamative, or peeling, and not weeping. In this feature it differs from eczema. It is absolutely universal. From the fingers and palms the skin is peeling in thick flakes. Everywhere else the skin is branny. His feet and legs are swollen, and perhaps there is a little swelling of the skin generally. Nowhere, although the skin is very red, is there any positive moisture. It comes nearest to moist eczema in the clefts of the groins and at the anus. It itches somewhat, especially if he is stripped in the cold. He sometimes wakes scratching. I ordered alkali, with aconite and lead and tar-wash. He is no better after a fortnight's trial of it. It has desquamated more, and has spread to the hands and feet. He does not easily perspire, but feels very weak, and on two occasions in bed has sweat profusely.

Tongue nearly clean. Urine scanty and bowels costive.

In speculating as to the cause of this severe attack, we may take into account the following facts:—

He is of gouty family, and has himself been threatened. Indeed, one great toe has been aching in a suspicious way

since the attack began. Against the idea of gout, however, is the fact that for three years he has been a total abstainer, and has always lived carefully.

He tells me that in early and middle life he used to perspire very easily, and, being fond of exercise, used to sweat much. Three years ago he noticed a change in this respect, finding that his skin did not so easily become moist. He then took to Turkish baths, of which he became very fond.

*Acute general Pruriginous Eczema in an old man.*

I saw with Dr. S——, at his residence in Kensington, an old gentleman of 94, who in his youth had served with Wellington in Spain. Until within a few weeks of my seeing him he had been able to take his daily walk in the park, and had enjoyed fairly good health. He was now suffering from prurigo of such severity that he was praying for death. In spite of chloral and opiates, his nights had been almost sleepless. Dr. S—— told me that when the prurigo first set in there was little or nothing to be found on the skin, but now, under the influence of scratching, &c., almost the whole surface had become erythematous, and here and there there was pitting on pressure, more especially on the legs. On the most careful inspection I could not find any papules, nor any evidence of bites. A single pediculus had been caught some months ago, but since then the most careful search had been repeatedly made without result. I was told that the eruption had first shown itself on his feet. Although I have called it erythema, it was really eczematous in many parts. As yet no papules whatever had been produced by scratching; indeed he had been in the habit of rubbing rather than scratching. There was a history of gout in the family, but our patient himself had been very abstemious, and had for some years drank almost solely milk.

I advised that our patient should constantly keep in bed, and be wrapped in a weak lotion of tar and lead; that arsenic should be avoided, and that he should take much less milk. A mixture was prescribed containing an alkali with small doses of colchicum.

*General Eczema of the Aged—Illustration of treatment by Tar.*

My friend Dr. H. D——, a not undistinguished physician, offered a good example of senile eczema. He was sixty-two years of age when it began. He had suffered for five months when he came to me, and it was gradually spreading over the whole body, limbs and face. His cheeks and ears were covered with it. It had advanced in spite of many remedies which he had tried, and was very irritable. He was a thin, spare man, with gouty and dyspeptic antecedents. I told him that it was serious, and that he had better go to bed for a time, and use weak tar lotions and take tar internally. I saw him on May 7th, and on the 12th he wrote me a letter from which the following is an extract :—

No other word than "specific" will adequately express the effect of your Tar treatment upon my eczema. Within forty-eight hours my face was practically well, and all the rest of the rash was evidently "killed."

Considering that it had been advancing for four months in spite of much internal and external treatment, this was truly remarkable.

My wife kept me well soaked in the tar till Thursday (it was Monday afternoon before the treatment was begun). On Thursday, the raw and oozing patches on my shoulders and back were all dry, and sufficiently healed not to stick to my clothes, and my face was well; so we came home, and I had a fairly pleasant journey instead of one of absolute misery as on going up the Thursday previous. I had a fair night Thursday—was seeing patients in my consulting-room from ten till one, and did some consulting out of doors, all with comparative comfort. I have kept up the Tar, undressing and well soaking three times a day, and a bath at night. All points and hard papules are gone, only red dry patches remain. They are easily irritated, and prick and tingle, but that is all.

In this case it will be seen that although the disease began in winter, it only assumed a troublesome form when warm weather set in.

## THERAPEUTICS, ETC.

### No. XXXV.—*On details in prescribing the Iodides.*

From my earliest days of practice I have been in the habit of never ordering iodide of potassium without the addition of ammonia, and I have taken many opportunities of strongly advocating this custom. I learnt it, I believe, either from Sir William Gull or Sir James Paget;\* perhaps from both. It has been my experience that many patients, respecting whom I was told either that they could not bear iodide of potassium or that it had failed to cure, were at once and definitely relieved by my prescription. The combination amounts possibly to giving the iodide of ammonium with iodide of potassium. Whatever the chemistry of the combination may be, however, I feel no doubt that the ammonia doubles the efficiency of the potassium salt, and at the same time does much to prevent its disagreement. During the last twenty years I have been in the habit of very frequently using another combination, of the value of which I have a very high opinion. It is the three iodides together, viz. the iodides of potassium, sodium, and ammonium. With the three in combination, some additional ammonia being of course added, I believe that a much smaller dose will accomplish the cure than with any one. I have expressed this opinion in print repeatedly, and my reason for recurring to it now is that I observe in a recent paper by Eulenberg that he has arrived at the same conclusion as regards the bromide salts in the cure of epilepsy. He uses the potassium, sodium, and ammonium salts together; and holds that in such combination they are much more efficient than would be the same dose of any one alone.

As regards the use of the iodides in general, I may say that I have always avoided, as much as possible, giving very

\* See a note, by myself, in *Medical Times and Gazette*, May, 1854, p. 488.

large doses, and that I use them much less freely now than I did in years gone by. Even with the most scrupulous attention to idiosyncrasy and the careful avoidance of these salts in those patients in whom they are little less than active poisons, they are yet apt to produce in many persons, who seem to be bearing them fairly well, conditions of serious depression of nerve tone. Some patients will tell us that they always feel better when taking iodides; but others, and I think a larger number, will say that, although they find them necessary in order to control local disease, they always find themselves living in a low key whilst taking them. The few scraps of clinical experience which fall to my share in reference to the use of bromides in those liable to epilepsy, incline me to the belief that, even in that malady, the cure is often worse than the disease, and that the prevention of the attacks is only accomplished by keeping the patient permanently in a state of low tone, and inflicting serious damage upon the mental powers. *Ægrescitque Medendo.*

*cf.*

#### No. XXXVI.—*The treatment of Psoriasis.*

It is, I think, very desirable, from time to time, to place on record examples of definite success in the treatment, even of common diseases. It is as one of these that I record the following case. It was one of the most severe forms of psoriasis which I have ever seen. The patient was a man who gave his remedies a fair chance; and the results were such as very much surprised him.

Mr. B——, a robust man, aged 50, who had never known a day's illness in his life, came to me on March 13, 1893, on account of psoriasis, from which he had suffered for twenty years. It had begun on his scalp, and only during the last eight or nine years had it affected his limbs much. The patches were of all sizes, from that of peas to that of a small plate; and they were covered with silvery scales or thick, horn-like crusts. Many of those on his arms and legs showed deep fissures. Although still in excellent health, he was in a very miserable condition, and having had much specialist treatment, with but temporary benefit, he had become very

desponding. During the last few months he had done little or nothing; but in former years he had taken much arsenic. When I remarked that my treatment would be chiefly by an ointment, he replied, "But, you see, I shall need a firkin at least." The ointment which I ordered contained \* chrysophanic acid, creasote, the liquor carbonis, and the ammonio-chloride of mercury; and was made up in pots of ten ounces, with the direction that he should use it very freely indeed, night and morning. He was also to soak himself every night in a hot bath containing a teaspoonful of the liquor carbonis detergens to the gallon of water. By means of this bath the scales were to be removed as much as possible before the ointment was rubbed in. He was also to take a dose containing one-sixteenth grain of tartarized antimony, every four hours.

When I saw Mr. B—— a fortnight later (in consultation with my friend Dr. Brodie Sewell), all his patches were free from scales, and the fissures were healed. The antimony had not depressed him in the least, and he felt quite well. With some slight modifications the treatment was continued. A month later, being almost well, he left off the antimony, but continued his tar-bath and the ointment. In the beginning of July, *i.e.*, about three months from the commencement of the treatment, he came to me in order to show that his skin was quite clear, and to ask for advice as to the prevention of recurrence. I then told him to keep the ointment constantly by him, and should any spots reappear, to immediately attack them.

In connection with this case, I may venture to offer the following memoranda as to the treatment of common psoriasis:—

1. In all cases alcoholic stimulants should be forbidden. Those who persist in intemperance are incurable. An ointment containing the ingredients above mentioned, varying in proportion according to the delicacy of the skin, is by far the most efficient means of treatment. It must be used very

\* I have not given the exact proportions of these ingredients, because they were varied from time to time. The chrysophanic acid, which was the principal one, was in the proportion of half a drachm to the ounce, more or less, and the creasote about ten drops.



freely, without regard to the underclothing or bed-linen. The regular use of a hot bath softens the skin and prepares it to receive the ointment.

The addition to the bath of the liquor carbonis detergens, or of the carbonate of soda, or both, in the proportion of a drachm to the gallon, very much increases its efficiency.

Although arsenic exercises a specific influence over psoriasis, and is in many cases the best internal remedy, there are yet many cases in which it is better to avoid it.

Arsenic should be avoided in most cases in which the patient has taken it often and for long periods.

Tartarised antimony in small doses will be often found useful in cases not suitable for arsenic.

#### No. XXXVII.—*Nux Vomica as a Tonic.*

A lady, for whom I had prescribed a mixture containing the tincture of nux vomica, applied to me three years afterwards to know if there was any harm in continuing it. She had taken it during the whole time, and her testimony was: "I cannot live without the mixture. If I leave it off for a fortnight, I cannot sleep. I become nervous and as if I must cry all day long. When I take it I am in good spirits, and have fair energy."

This patient was a lady, aged 49, who inherited gout, and had a very feeble circulation. She consulted me, in the first instance, on account of symptoms of rheumatic gout, and I had been obliged to put her on a somewhat restricted diet and to advise abstinence from wine. She bore the most emphatic testimony to the improvement in her general health which had resulted, and she had got quite rid of all symptoms of arthritis. As has just been noted, however, she was unable to maintain her tone without the nux vomica. The dose which she had taken was ten minims of the tincture three times a day before meals. I have met with many patients such as the above, who found that nux vomica suited them better than any other kind of tonic, and that they could take it for very long periods without any failure of the effect. It is, I feel sure, the very best substitute for wine and beer, and is often very superior in its effects to either. Like them, it

should be considered as an article of diet rather than a medicine, and, when it agrees, it may be continued indefinitely.

No. XXXVIII.—*Dermatitis Herpetiformis with Stomatitis—Remarkable effects of Arsenic.*

Miss E. L——, aged 52, was brought to me by Mr. Hugh Smith, of Farningham, on July 7, 1891. She had been suffering since November, 1889, from a vesicating eruption on her body and limbs, accompanied by sores on the sides of her tongue and in her cheeks. The eruption on her body did not begin till August, 1890, nearly a year after the first appearance of the sore mouth. The eruption was described as having consisted chiefly of "blotches and blisters." When she came to me it was almost confined to her legs, on which there were large reddened areas with bullæ. She had been given arsenic in combination with iodides, and was improving. Her mouth had often been so sore for a time, that she could take nothing but milk. I advised that she should abstain from iodide of potassium and take arsenic in increased doses, and in combination with opium. Six weeks later I heard from Mr. Hugh Smith that she was almost well. This good result was, however, not wholly maintained in the sequel.

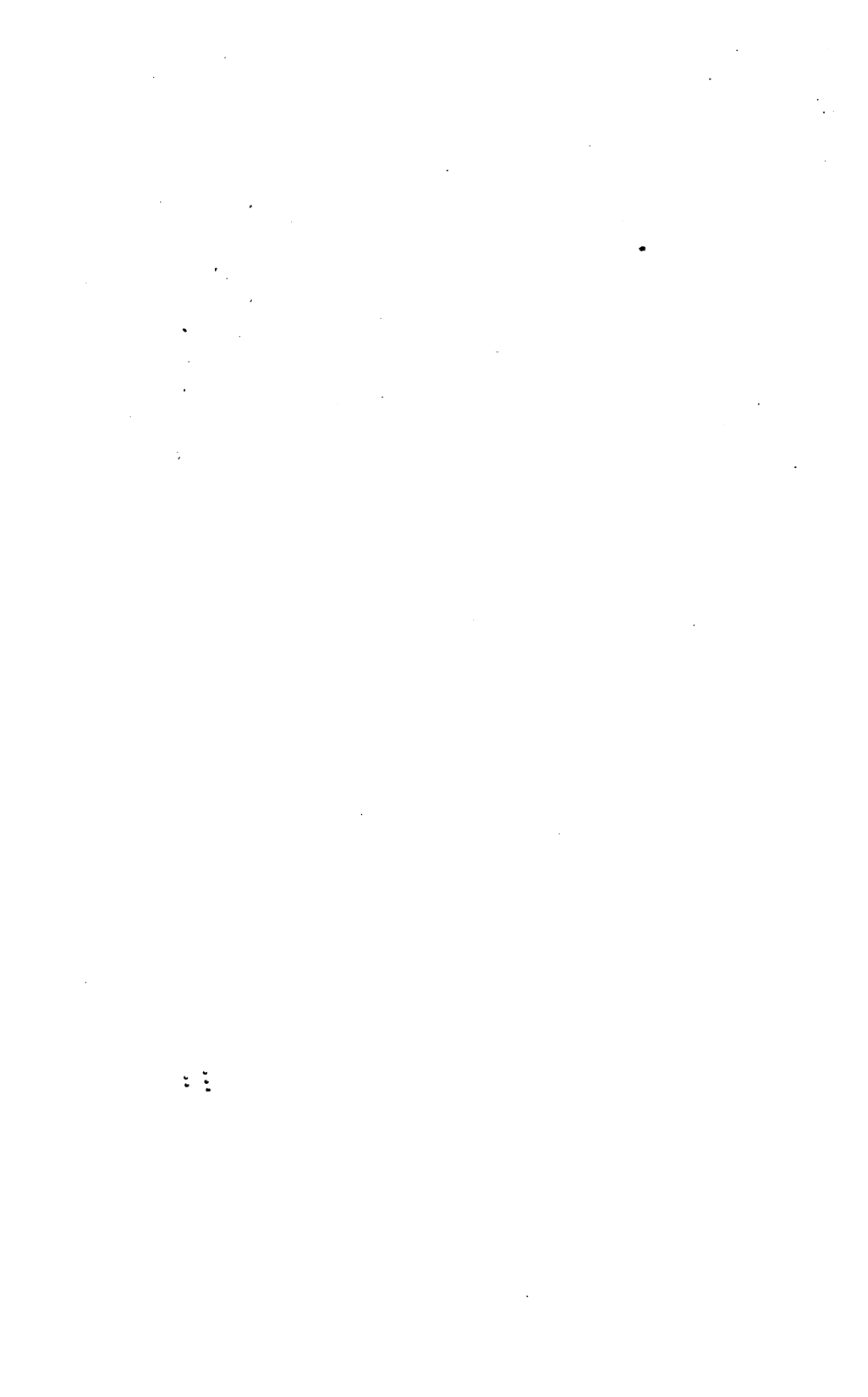
Miss L—— came to me again, at my request, in August, 1893. Her report was that she had taken her medicine very irregularly. She thought that she had usually been better when taking it. She had had frequent relapses of vesicles as large as peas on the legs and arms, and sometimes also on the trunk. They would come out in many places at the same time. She said that her skin was always more painful just before the vesicles appeared than after they had developed. In this respect her eruption conformed to what is constantly observed in true herpes. She had also frequently herpetic vesicles on her tongue and lips, which were very sore. She had indeed rarely been long free from vesicles either in the mouth or on the limbs. There could be no doubt that her eruption was in the main of the herpetic type. I urged her to take her medicine more regularly, with a view of definitely

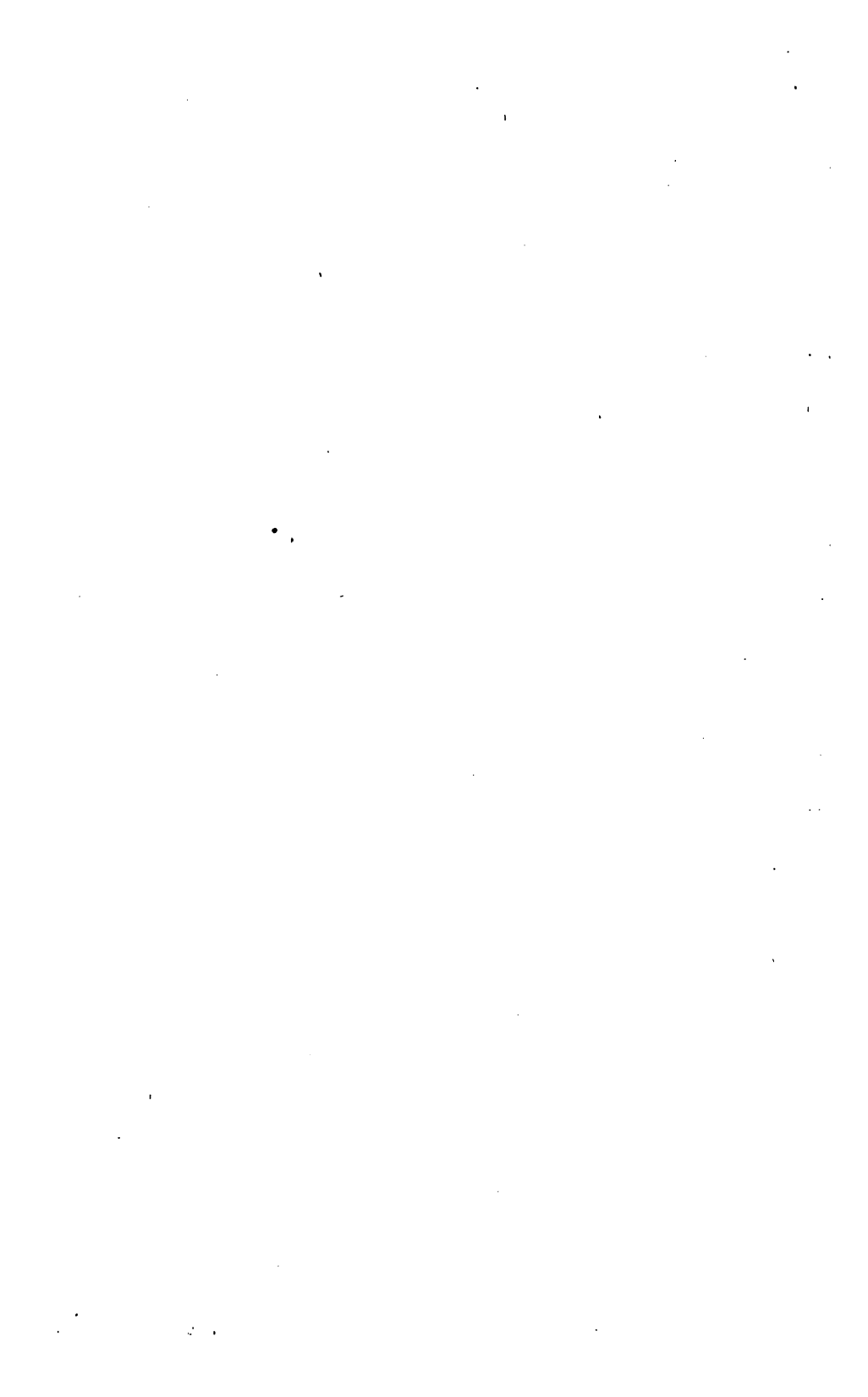


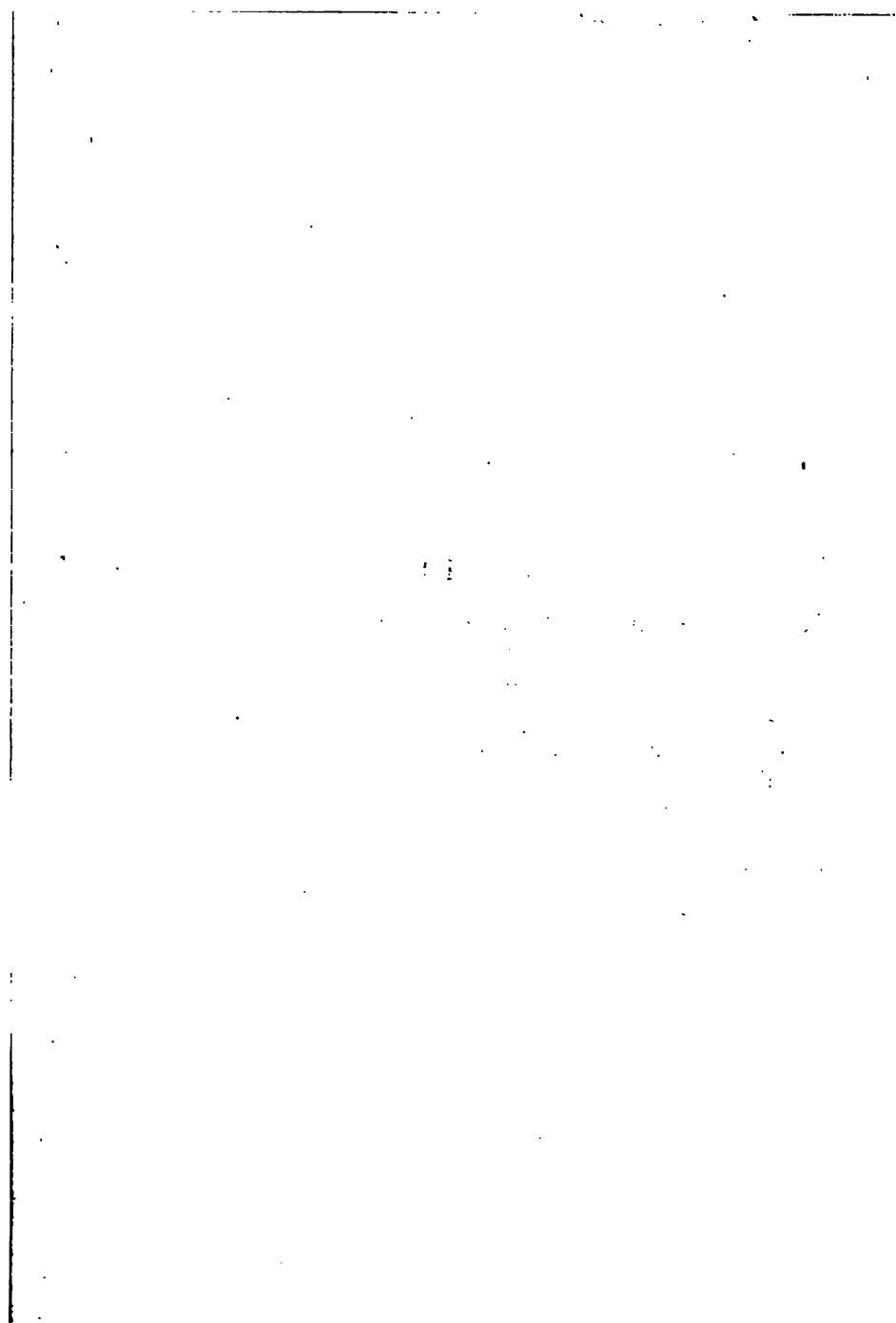
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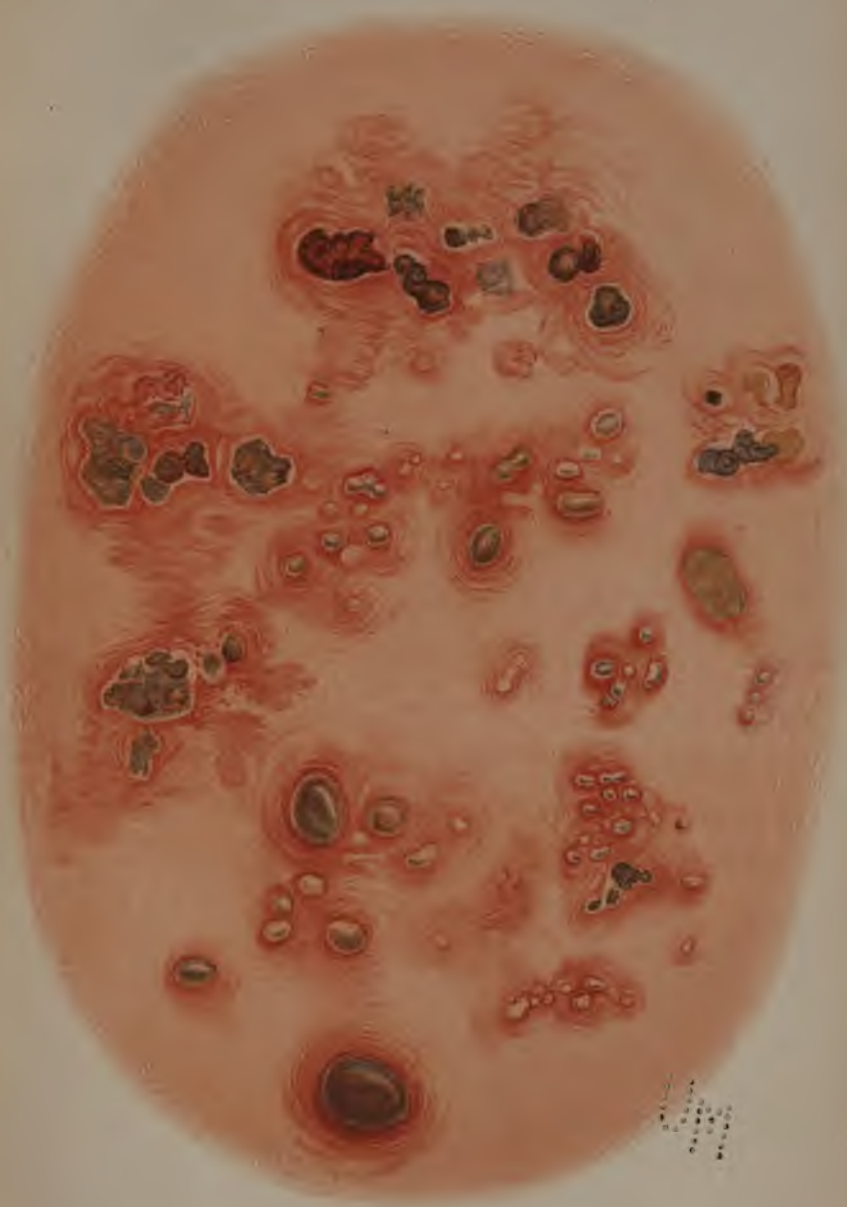












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testing its power in preventing the eruption. I gave her a fresh prescription for larger doses of arsenic.

A fortnight after I had increased the arsenic, Miss L—— wrote to me: "As soon as I began taking the medicine, the places that I complain of began to come out. Now they are all over my legs, arms, and body. They have not formed into blisters; but the burning and irritation are intense, and at times almost unbearable. The medicine also seems to affect my eyes and makes them burn, and they are inflamed. I have taken the medicine quite regularly."

Miss L—— called on me again a month later. On August 29th I noted:—I saw her last on August 1st. She had then one blister on the right elbow. The skin was quite sound elsewhere. I ordered Liq. Sodæ Ars. m iv., Liq. Arsenicalis m ij. in Tinct. Aurant., with m iv. of Cascara. Immediately after beginning this medicine the eruption began to spread, and a week later, when she went to Eastbourne, it came out profusely. Her limbs and trunk were covered, *her face, hands, and feet escaped, as always before*. She continued the medicine regularly. The skin burned intolerably, and her eyes were irritable. The eruption consisted of erythematous patches, which spread at their edges and covered large areas—in fact, involved the whole surface. These patches were swollen and distinctly œdematous. She shows me to-day, after taking the arsenic one month, the remains of these patches. They still pit on pressure at their aggressive borders. They have subsided and become pale in their centres. A peculiarity of the present attack is that there has been no vesication. Usually the development of blisters relieves the burning. Her tongue is furred. She feels faint, sick, and sinking at times. Has had very bad nights. Any food, even a glass of milk, induces a burning heat in the skin as if scalded. The bowels have been regular. She can read, but not for long. Eyes not red; lower eyelids a little puffy; black freckles. She speaks as if a little hoarse. Advised to take half-doses.

On Sept. 28th, under the smaller doses of arsenic, Miss L—— was absolutely free from her eruption and in good health.

## GOUT AND RHEUMATISM.

### No. XXXIII.—*Calcareous bands in the Corneæ in association with Gout.*

In a recent number of ARCHIVES I described (perhaps for the first time) the formation of minute tophi in the iris. Since then I have carefully inspected the eyes of many gouty subjects, but have not found another instance of it.

There is a very peculiar and very rare condition of disease of the cornea occasionally seen in gouty patients. It consists in the deposit of a broad white band which crosses the front of the cornea horizontally. It is usually symmetrical, and so superficial that it may be scraped away, without causing any damage to the substance of the cornea. It is chemically the sodium urate. Its subjects are always gouty persons, although, not infrequently, the proof of extant gout may not be very definite. This condition was, I believe, first described by Mr. James Dixon. I have myself seen and recorded several examples of it, and some have been published by Mr. Nettleship and other observers. I now publish another case, taken from an old note-book. The condition is so rare, that I have not for many years seen an example of it.

It is of much interest to note that neither in the deposits in the iris nor in those which form bands across the cornea is any inflammation produced. The deposit appears to take place quite quietly; and we also note as a feature common to both, that the influence of light seems to have some effect in locating the deposit. The corneal bands are always in that part of the cornea least covered by the eyelids; and the same statement is true of both eyes in the only case in which I have seen the iris affected. In this instance the upper part of the iris, where covered by the upper lid, was quite free, and

the lower portion, where partially protected by the lower lid, was almost so, the largest deposits occurring opposite the canthi, just where most constantly exposed to light.

The following are the brief notes of the case which has been the occasion of my making the above observations.

In February, 1874, I saw a man named Higgs, aged 41, who had these transverse bands on both corneæ. The other parts of the corneæ were clear. I have preserved no note as to history of gout, but the following items of evidence are not unimportant. He had for long habitually used atropia, and in both eyes there were pupillary adhesions, and in the left the lens was opaque. He had not seen well since boyhood, and although he had never had any attack of inflammation, he had often, about the age of 27, had the eyes red and irritable. These are precisely the usual concomitants of the iritis of inherited gout. I saw the man only once.

No. XXXIV. — *Effect of Exercise as a guide to diagnosis in arthritic maladies.*

A test which is often very useful in reference to the diagnosis of the rheumatic or gouty origin of arthritis, is the influence of exercise upon the pain and stiffness. Patients with scrofulous joints, or with synovitis of a non-rheumatic character, often find it quite impossible to use the joint; whilst, on the contrary, those who suffer from chronic rheumatism are usually relieved by exercise. This is by no means an invariable result, but it is sufficiently definite to be of great value in practice. The gouty rheumatic pain, known as lumbago, may, as is well known, almost invariably be dissipated by resolute exercise.

In illustration of these remarks I may quote the case of a lady of 35 who was sent to me on account of stiffness and pain in her knee-joints. The question was whether she ought to rest them or not. The joints were but little swollen, but both of them creaked very definitely on movement. The patient had also creaking in other joints, *e.g.*, shoulder and wrist. She told me that her knees often felt so stiff that she could scarcely walk, and the attempt to do so always gave her

pain; but she added, "I can always walk off the pain," and "I have been to dances when I had so much pain and stiffness that I could scarcely move, but have got quite well during the evening, and the next day have had little or no pain." With such a history I felt no hesitation in advising that the patient should continue to take as much exercise as she could, and on no account to be persuaded to rest. Although there was no recognised history of gout, Miss H—— said that her father had suffered a good deal from pains in his joints. She said that her own joints were always more comfortable in weather which was either very cold or very hot, and always worse when the air was damp or during the prevalence of east winds. It is just one of the cases which may end in a general crippling, but I feel sure that the evil day will be deferred by resolute exertion. Were the patient allowed to take to her couch, the joints would rapidly stiffen.

No. XXXV.—*The relationships of Gout and Rheumatism.*

I have long held that by far the principal clue to the interpretation of the relationships between gout, rheumatic gout, and rheumatism, is to be found in the laws of hereditary transmission. In reference to this I have also endeavoured to point out the importance of recording details as to various members of the same family, and have ventured to suggest that those engaged in a country practice might often find good opportunities of rendering service to science in this direction. In consultation practice we but too often see only fragments of cases, and it occurs to us but very rarely to be consulted by many members of the same family. An exception to this has just happened to myself, for I have been made acquainted with the fact that five persons, who at different periods during the last twenty years have been under my care and of whose cases I have taken notes, are brothers and sisters. In addition to these five, all of whom are elderly, I have seen several of the next generation. It is known that on the father's side there is a history of true gout, the father himself having suffered from several attacks. It is

not thought, however, that the tendency existed in any very intense form.

The first case, which I will relate, is that of a fine old lady, Mrs. C——, aged seventy and the subject of *morbus coxæ senilis* on both sides. She is the youngest of the family. There were originally twelve, and although, as I have said, she is seventy, she still has seven brothers and sisters living, the family being remarkable for longevity during several generations. I have seen Mrs. C—— twice, first in 1882, and secondly during May of the present year. She came to me in the first instance with stiffness and pain in her left hip, which were then of two years' duration. She appeared to be in excellent health; but was liable to attacks of thrombotic purpura in her legs with œdema. In early life she had been accustomed to take malt liquor and to live generously. She was exceedingly active in parish affairs: I sent her to Droitwich, and prescribed various remedies for her arthritis. Eleven years later she came to report progress, and suffering from another attack of œdema of the legs. She was still a cheerful, hale old lady, florid and very stout. She told me that the pain in her left hip, which had been very severe when I saw her before, had gradually ceased, but that the joints had stiffened, and the limb lengthened. She illustrated the fact of lengthening by stating that it was quite impossible to kneel with the two knees bearing equally on the same cushion, for that the left thigh appeared to her at least an inch and a half longer than the other. She was so stout, that I did not care to undertake the almost hopeless task of ascertaining the cause of this. In probability it was due to tilting of the pelvis. She had of late years had a high-heeled boot made for the other limb. When the pain ceased in her left hip, her right began to suffer, and both had now become very stiff. She could still hobble about by the help of a stick and her daughter's arm, but was so lame that she scarcely ever walked, and she could neither lie down flat in bed nor sit back in her chair. She habitually sat on the edge of the chair, and in bed was propped up in a half sitting position. None of her large joints, excepting her two hips, had suffered; but the joints of her fingers, especially the terminal ones, were much deformed

and stiffened. I could not detect any chalk stones. Her nails were not of the ordinary gouty type, but thin, soft, and fluted. She said they had been so all her life; but I was inclined to suspect that their condition was in part due to the acro-arthritis from which she suffered. Her arteries were dilated and her pulse was firm. She was not in the least deaf, and said that deafness was not in her family. Since my first recommendation of Droitwich, she had visited repeatedly not only that place but Buxton and Bath, and averred with emphasis that she had never derived the slightest benefit from any of them. Nothing, she said, had ever done the least good. Whilst at Buxton she had had an attack of acute gout in her foot, the only one from which she had ever suffered. One of her sons had had an attack of rheumatic fever; but, with this exception, none of her four children had as yet shown any definite tendency to arthritis. I have only to add respecting this patient that she began to suffer from rheumatism in her hip soon after a change of residence to a somewhat damp locality not far from the Thames, where she had continued to live ever since.

Mr. C——, aged 33, the son of this patient, consulted me on account of pain and stiffness in many of his joints. He said that he was quite well so long as he was taking violent exercise, but that he got stiff if he sat down. He had recently been obliged to give up malt liquor because he thought it made his joints worse. He had once been in bed a week with what was called “a threatening of rheumatic fever,” and he had once suffered an attack of quite painless discharge from the urethra, which the doctor, whom he consulted, said was not a true gonorrhœa, but a consequence of gout.

Mr. R. F——, an old gentleman of seventy, of feeble circulation, was under my care in May, 1891, for rheumatic gout in his left knee. He had also some stiffness of his finger joints. He told me that kidney disease, diabetes, and albuminuria were in his family, and that his father had suffered from true gout. He was Mrs. C——’s brother.

Mrs. M——, an old lady of seventy-two, a sister of Mrs. C——, in excellent preservation, came to me in August, 1891, on account of chronic rheumatism in both  
s and in her right shoulder.



## NOTES ON CANCER AND CANCEROUS PROCESSES.

### *Senile Freckles with deep Staining—A superficial Epithelioma on the Cheek.*

I add the following to other cases recently recorded in my ARCHIVES which illustrate the connection between senile freckles and epithelial cancer.

Mrs. J——, aged 71, was sent to me in April on account of a “papilloma” on her face. The disease consisted in a very superficial patch of rodent on her left cheek. It was as big as a shilling, and although it showed some scar and a slightly-marked rodent edge, it could not be said to be ulcerated. I was told it had been present two years or more. My interest was especially attracted to the case from the circumstance that the old lady was the subject of senile freckles. Her lower eyelid, and especially that of the left side, showed groups of freckles of large size, and almost black in colour. They had not coalesced so as to form patches of melanotic staining, but in size they closely approached to that condition, and, after all, the difference is probably only one of degree.

### *Senile Freckles and Epithelial Cancer in association with them. —Disappearance of Keloid in old age.*

An old gentleman of 72, Mr. G——, who consulted me many years ago on account of a large keloid scar on his back, has recently (June 1, 1893) come again under my observation, on account of hydrocele. He has now senile freckles on his hands and nose, and, in association with them, a warty, rodent ulcer on the latter. A point of much interest is that his keloid, which was of long duration, has entirely softened away. The site is now occupied by a supple, bluish scar, as big as an outspread hand. The keloid had followed a burn, and had persisted nearly twenty years.

*Melanotic Staining of Lip.*

Mr. W——, aged 41, has a black stain on the mucus membrane of his lower lip as big as a sixpence, not quite round, and not very definitely margined. It has been there for a year at least, and is increasing. There is not the slightest thickening or soreness, but he formerly had sore lips from tertiary syphilis. He is in an early stage of the condition illustrated in Mr. Willett's remarkable case.

*Melanotic Staining of Mucous Membrane of Lip.*

There is a model in the St. Louis Museum in Paris, which represents exactly the same state of things as that which I have described in Mr. Willett's case, ARCHIVES, Vol. IV. p. 62.

The mucous membrane of the lower lip is affected. There is very extensive coal-black staining. This involves the lining of almost the whole lip. It is staining only: there is no thickening and no ulceration. In the middle, however, there is a growth, as big as a nut, deeply ulcerated, and, although apparently not pigmented in its substance, quite black at its edges.

This specimen is numbered 443, XLVII, and was placed in the museum in 1877 by M. Vidal. No history is given in the catalogue. It is named "Sarcome Mélanique de la Lièvre."

There was also a drawing shown in the Vienna Congress Museum (Leopold Bauhofer), in which melanotic staining was associated with a cancerous growth. It was designated "Carcinoma faciei."

*Melanoid Staining of Prepuce with Melanotic Sarcoma.*

Another remarkable instance of the association of melanoid staining with cancerous growth came under my observation in the person of a gentleman from near Winchester. The part affected was the prepuce. The prepuce could not be retracted; but a large patch of deep brown staining, abruptly margined, was seen passing from its mucous surface over the free edge upon the skin. Its base was infiltrated and very hard, the induration ceasing abruptly at the corona. The glans could not be exposed to view. There was much dirty discharge from under the prepuce.

There was no history that the melanoid staining had long preceded the growth; but the patient had been very unobservant, and the fact that there was a growth at all had only been discovered by his surgeon (Mr. Roberts, of Twyford), who had been called in to pass a catheter. The old gentleman held that both the staining and the growth had commenced together, about six months previous to my seeing him. There was no evidence of any gland implication, or of deposits in the viscera, and I recommended that immediate operation should be performed, for which purpose he returned home.

Mr. Roberts, in the operation, found that the prepuce alone was involved in the growth. The latter consisted of a thick mass, in part pigmented, in part not so. It is the first case of melanosis of the prepuce which I have seen.

*Malignant Disease of the Thyroid Gland—Very rapid growth.*

I saw Mrs. P——, aged 56, in consultation with Dr. Roland Smith, on October 9, 1891. For the past two months she had noticed a swelling in the neck, rapidly growing, but quite painless. I found a large fixed mass of almost stony hardness adherent to the sternum. One nodule projected between the sternal and clavicular heads of the sterno-mastoid muscle.

Dr. Roland Smith was good enough afterwards to report to me. His patient had died on November 27th, that is, about two months after our consultation, and within four of her having first noticed that her collars were tight on her neck. The swelling had increased before her death, but had not caused permanent obstruction either to the trachea or œsophagus. She had, however, experienced attacks of painful breathlessness, and had become very feeble. During the last week of life she had fainted several times, and there had been a condition of permanent cyanosis. Her death was finally quite sudden. Dr. Smith's belief was that the cause of death was pressure involving the pneumogastrics, one or both, and that it certainly could not be attributed to exhaustion.

*Sebaceous Cysts of Scalp assuming Sarcomatous characters.*

With a label "Molluscum Generalisé, Tumeurs Atheromateuses," there is in the Museum of the St. Louis Hospital

a model which shows, if I mistake not, the same condition as that in two others which I have described (see ARCHIVES III. 336). It is No. 859 in XXXIII. In the Catalogue, the term "Molluscum" is very properly omitted, and the designation stands, "Tumeurs atheromateuses—Face et crâne." The tumours are evidently solid, and many of them much congested. Many occur on the temple and face. These features wholly separate the case from one of ordinary sebaceous cysts. No history is given, but I have little hesitation in assigning the case to the group referred to, of which it makes a third.

*Lupus on the face in two aged persons—Cancer of the Scar in both.*

A few weeks after I had seen the patient at the Kensington Workhouse whose case I have previously described, an old woman presented herself at the Stamford Street Hospital whose condition was so exactly similar that I had some difficulty in persuading myself that she was not the same individual. She was near eighty years of age, and her whole face was covered with symmetrical bat's wings of superficial lupus. Her alæ nasi were notched, and the tip of the nose destroyed, and in the middle of one cheek, on the lupus scar, there was a round patch of cancerous growth. The conditions of the latter were exactly like those in the Kensington patient, the border being slightly elevated (like rodent), and the centre presenting low fungating granulations. The main difference between the two patients was that in one the cancerous patch was on the left cheek, and in the other on the right. The old woman said that her lupus had begun, not on her nose, but on the cheek, almost in the exact position of the patch of cancer. The lupus had begun about twelve years ago, and the cancer not till ten years later. There was no gland disease. The patient had suffered somewhat from rheumatism, but had in other respects enjoyed excellent health through her long life. She knew of no history of scrofula or consumption either among her relatives or her own children. One ear was wholly involved, on all parts, by the extension of lupus from the cheek, but the other ear was quite free, and showed nothing in the concha.

## MISCELLANEOUS.

### No. CVII.—*Against Trouser-Pockets.*

A very important precaution in all cases of chancre is to instruct the patient to remove everything from his trouser-pockets. Coins or keys, or both, carried so as to press upon the groins, are very apt to irritate the inguinal glands, and if the latter are inflamed, to increase the risk of their supuration. Patients who suffer from varicose veins in the leg, should also be warned in like manner. The impediment to the return of blood, which any weight in the pocket will easily cause, may constitute a not unimportant source of aggravation to the discomfort which attends varices. It would indeed be a decided improvement in dress if the trouser-pockets in front were abolished. In addition to what I have mentioned, it is to be remembered that cases of varicocele and of neuralgia of the testis, as well as all forms of orchitis, are liable to be much irritated by coins in the trouser-pocket.

### No. CVIII.—*On estimating the Symptom of Pulsation*

It is not unimportant to note that in estimating the symptom of pulsation when it is very feeble, the eye is a far better judge than the hand. A feeble beating which cannot be perceived by the fingers or by the outspread hand, may sometimes be recognised at a glance by the eye. This especially applies to tumours communicating with the skull, and I cannot illustrate it better than by quoting the following instance of it. A child, six years old, was brought to me with the anterior fontanelle much depressed, and it was a question whether it was or was not closed. Her mother

assured me that when the child was nervous she could see it beating, but on the most careful examination by the touch I failed to detect any pulsation. I tried the tips of the fingers and the flat palm, and tried the lightest possible pressure as well as firmer; but although now and then I might have fancied that it beat, I could not feel sure. The membrane was stretched so tightly across that I had even an impression that it was ossified. A few minutes after concluding this very careful, but wholly negative, tactual examination, I could see the whole space pulsating quite vigorously. Again I tried the fingers, and again with the same negative result. A surgeon who was in consultation in the case received the same impressions as myself; by the hand it was impossible to perceive it, but to the eye it was very conspicuous. I have repeatedly noticed the same in cerebral tumours and in cases of exposure of the cerebral membranes, and am convinced that it would often save much trouble to abstain from any attempt at feeling for pulsation, and trust to the eye. At any rate, the use of the eye should never be omitted where the presence or absence of pulsation is in question. There are, of course, mechanical means by which the eye may be assisted, such as fixing a little flag as a lever over the suspected swelling, but they will seldom be necessary.

#### No. CIX.—*Chronic Balanitis.*

There is a very peculiar form of balanitis, which in my experience occurs only to middle-aged or elderly men. The balanitis which is so common in boys and young men from neglect of washing, is, I think, always a diffuse inflammation of the preputial sulcus. That to which I now refer as peculiar to those advanced in life, occurs always in abruptly margined patches. The affected areas are as abruptly margined as the islands on a map, and they are remarkably persistent. This form of balanitis is a rare affection, even in the aged; for in the latter, as in the young, the diffuse form is much the more common. Diffuse balanitis may usually be cured very quickly by free irrigation with hot water, or by the use of some weak astringent lotion. The map form, however, resists, not only

these simple measures, but almost every kind of ointment or lotion that can be devised. I have had under care some very marked examples of it, and they have always been very obstinate. At page 18, Vol. II. ARCHIVES, I have recorded two examples of this condition, under the name of balanitis perstans. The form which I there described was one in which the patches would become red and glazed, there being exceedingly little evidence of secretion. This dry state is, however, not an invariable condition.

I have just seen, in consultation with Dr. Burnett, of Wimpole Street, a widower, aged 60, who has been annoyed for a year past with this balanitis in patches. It has been sometimes better and sometimes worse, never quite well. When at its worst the patches secrete pus freely; and at no time do they present the dry, glazy condition which I described as a peculiarity in my former paper. In Dr. Burnett's patient there is no special cause to be assigned. He is in good health, and has not been able to observe that anything in his diet influences the condition. He had, as was the case with other patients, tried a variety of remedies without success, before I was consulted.

No. CX.—*Scabies affecting the Glans Penis.*

It is not so generally known as is desirable that the eruption of scabies may affect the glans penis. Whether the sarcoptes can really burrow and live in a moist mucous membrane I do not know. It would seem very improbable. That, however, an eruption may occur on the glans, in connection with scabies, is most unquestionable. As it is attended by superficial ulceration and the formation of crusts, it might very easily lead to an error in diagnosis. I have just seen such a case. A gentleman, aged 31, was covered from neck to foot with scabies, in all stages from minute vesicles to ecthyma. Although the irritation had been extreme, the diagnosis had been missed, and the disease had been present for three months. There were three crusted sores on his glans penis, each as large as a fourpenny-piece; and deceptively like non-indurated chancres. The inguinal lymphatics were slightly enlarged.

The occurrence of scabies on the glans penis is well acknowledged by French authorities, and there are in the museum of the Hôpital St. Louis several excellent models which show it.

No. CXI.—*Perforation of the Septum Nasi.*

A lady of sixty, the widow of an officer, consulted me on account of disease in her nose. I found a perforation in the septum, through which the tip of the finger might have been passed. Everywhere its edges were soundly healed, excepting posteriorly. The ulceration here appeared to be still progressive in the cartilage itself. There was no swelling of the mucous membrane, simply a narrow, grey, ashy line in the middle of the edge. On taking hold, with forceps, of the sloughy tissue, I found that it adhered quite firmly and clearly involved the cartilage. My impression is that this disease not unfrequently begins in the cartilage itself, and involves the mucous membrane only secondarily. It seldom shows any tendency to spread on the surface of the latter, and it almost always ends anteriorly with the cartilage, leaving the columna nasi untouched. Thus patients may have large perforations without any falling down of the tip of the nose. When the disease is syphilitic it tends to involve all structures alike, and the tip of the nose usually falls. In the present instance there was not the slightest external deformity of the nose. I applied nitric acid to the unhealthy border of cartilage. There were no indications of syphilis in the case. This patient during the last three years had twice suffered attacks of epistaxis which had necessitated plugging of the nostrils; but they had probably had nothing to do with the ulcerated septum.

No. CXII.—*Abscess simulating Malignant Disease.*

I have recently (June 1, 1893) seen a case of a tumour under the upper part of the sterno-cleido-mastoid, which I at first took to be a lympho-sarcoma; but it proved to be an abscess. The conditions under which this occurred were somewhat peculiar, and a memorandum of the case becomes



somewhat important for diagnosis. The patient was a very robust man, aged sixty-four, who had lived freely, and had never suffered from any form of struma. He had, however, sixteen years ago, had a lump form in the same place, for which he consulted the late Mr. Spence, of Edinburgh, and was for a time very anxious about it. This lump disappeared after a time under Mr. Spence's treatment. I had attended, about a year ago, a brother of the patient, for epithelial cancer of the tongue, attended by enlarged glands. The lump, for which I was consulted, had been forming about a month, and quite painlessly. It was a rounded mass, as big as a fist, and adhered to the adjacent parts. There were no enlarged glands to be detected near it. Handling the tumour gave no pain. I thought that there was a deeply seated sense of fluctuation; but upon this point opinions differed, and, on the whole, I was inclined to believe that it was a soft solid. As the diagnosis was doubtful, I sent the patient for a fortnight to the seaside, and administered iodide of potassium. When he returned at the end of the time, the tumour had increased in size, and there was a little reddening on its surface. I now felt no doubt as to there being fluctuation, but still thought it very possible that it was a malignant growth, which had suppurated. An incision, however, let out a large quantity of thick matter, which showed no mixture of broken-down tissue. Under poulticing, with the use of a drainage tube, the swelling rapidly subsided; and when Mr. B——, at the end of a fortnight, returned to his home, it appeared likely that he would soon be well.

The progress of the abscess in this case made it certain that it was neither of strumous or malignant origin, but leaves us quite in doubt as to the exciting cause. There was a remote history of syphilis (twenty years ago), and it appeared possible that the present attack was due to relighting of disease in a gland, which had been formerly enlarged. There was, however, nothing of the nature of a gumma on the present occasion.

#### No. CXIII.—*The Cardiac Sleep-start.*

Mr. B——, the subject of nervous exhaustion, describes this

symptom. He was previously quite familiar with the ordinary sleep-start (of muscular system), and says that this is quite different. Just as he gets to sleep he wakes with a feeling as if his heart was stopping, lifts his arms, and struggles for breath. At first there was a sense of impending death, but he has got used to the attacks, and is now not alarmed. They occur not only on going to sleep in bed, but if he falls asleep on his couch. They are followed by palpitation. There is no cardiac murmur. Mr. B—— is very decidedly out of tone. Once in the night he had an attack of unexplained shivering. He is married and has lost sex-desire. He is dyspeptic and liable to acidity. I make no doubt that the attacks are dependent upon deficient tone and nervous irritability, and should suspect sexual exhaustion in an over-worked man as the primary cause.

#### No. CXIV.—*Rider's Sprain.*

What is known amongst riders as the "rider's sprain" is, I believe, usually a rupture of part of the adductor magnus. It occurs when, in consequence of sudden emergency, the rider attempts to take a too vigorous grip of his saddle. The rupture is felt immediately, and is often followed by a fall. As in the case of "lawn-tennis sprains" and other ruptures of muscles, the recovery is usually almost perfect in the end, although it may be with some slight permanent weakness.

I have just seen a gentleman who told me that he had had two severe "rider's sprains," both in fox-hunting. The first of these, and much the most serious, occurred twelve years ago, and the last a few months ago. In the latter he did not fall from his horse, but was instantaneously and completely disabled in consequence of something giving way in the inner side of his thigh. He had been under treatment by bandaging, &c., ever since the accident, but was still quite unable to ride. On examining his knee I was somewhat astonished to find that there was a considerable bony mass developed along the line of insertion of the adductors, and just where he complained most of pain in connection with his second accident. It seemed probable that this had resulted from the injury

received on the first occasion. I found on inquiry that this had been more than a mere sprain, for his horse had rolled on him. It appeared certain, however, that there had been no fracture of the limb, for he had continued to walk about during the whole of the subsequent treatment. The patient was a strong, very muscular man, and probably the periosteum had been more or less detached.

No. CXV.—*Recovery from Obstruction without Laparotomy.*

Dr. Jennings, of Christchurch, records a case in which a woman of 41 was suddenly attacked by severe abdominal pain and vomiting. An elongated smooth tumour of considerable size was found in the right hypochondrium. A severe illness followed, with the usual symptoms of "intestinal obstruction," and much pain and sickness. The illness began on the 19th of September, 1891, and terminated by action of the bowels on the 23rd. There had been jaundice. The treatment had been by large enemata and morphia, with "cautious manipulation" of the tumour. The recovery was complete, and the large tumour disappeared. It was probably impacted feces, possibly magnesia and possibly charcoal. It may have been a case of gall-stone colic complicating an old-standing intestinal concretion. The symptoms were sufficiently severe to have warranted a laparotomy at any stage. (*New Zealand Journal*, April, 1890.)

No. CXVI.—*Inheritance from Mother of tendency to formation of an exostosis on the first phalanx of one finger.*

An example of an inherited peculiarity, which much excited my interest on account of the very remarkable similarity in parent and child, occurred in the person of a young lady, sent to me on account of an exostosis which grew from the base of the first phalanx of her left ring-finger. It was not in the least pedunculated, but consisted of a rounded, broadish ring of bone, which projected over the dorsal end of the phalanx just above the knuckle. The

extensor tendon crossed it in a furrow in the middle. It was a slight disfigurement, but caused no inconvenience, and being close to the joint I strongly advised that it should not be meddled with. It had been slowly growing during the patient's childhood, but I assured the parents that as she had now nearly attained adult age it would probably not grow any further. No other exostoses could be detected with the exception that the upper ends of the fibulæ were both of them considerably larger than natural. The interesting point in the case, and the one that induces me to record it, is that the girl's mother had on the same phalanx of the same hand a precisely similar, though much smaller, enlargement. In her it had developed during childhood and adolescence, but had not grown in the least since she attained maturity.

Dr. Charles Oliver, of Philadelphia, has recently recorded in the *Ophthalmic Review* (with woodcuts) an interesting case in which a mother and her son were the subjects of congenital opacities on the cornea. The opacities affected both eyes, and were almost exactly alike in the two patients. It appeared probable that, although present at the time of birth, the opacities had increased somewhat subsequently. The same statement was made as regards the exostosis above recorded.

No. CXVII.—*A Note on the Uncertainties of  
Nomenclature.*

I have several times recently thought it worth while to draw attention to local peculiarities in the nomenclature of disease. Thus we have seen that a century ago the word "croup" would not have been intelligible in Yorkshire, and that a little before that time the designation under which fatal cases of laryngitis were registered in Scotland was that of "closing." I have also adverted to the fact that the older writers on skin diseases, even as recently as Mr. Plumb, used the adjectives "lupinosa" and "favosa" for eruptions quite different from favus, to which alone modern writers would apply them. In corroboration of this latter statement, I take the following from a work published in 1833, by Mr.

George Macilwain, on "The Constitutional Origin of the various forms of Porrigo, commonly known by the names of Scald-head, Tinea, Ring-worm, &c." Mr. Macilwain writes, "The Porrigo Lupinosa has been with me a rare disease, and I believe it is not a very common variety in this country; but a very bad case of it yielded just as readily as any other to attention to the general health." It is remarkable that this author should have thought that scald-head and ring-worm were curable by constitutional treatment, but it may be taken as certain that no benefit would result to a case of true favus. The explanation of Mr. Macilwain's success, if he had it, was probably to be found in the circumstance that he was very attentive to cleanliness, and that he did actually use local treatment which was effectual, whilst he chose to attribute all the results to his constitutional measures. I am justified in saying this, because, after having spoken most depreciatingly of local treatment, he writes (see page 81), "I, prefer ung. hydrar. nitrat. variously diluted according to the susceptibility of the surface to which it is to be applied." And on another page he writes, "The local treatment is simple, yet each part of it should be carefully executed, regardless of the trouble it requires." Now the simple truth is that "the ointment of the nitrate of mercury variously diluted," but used, as it evidently was, as strong as the patient's skin could bear it, is one of the most efficient remedies that we possess. The man who was removing all crusts, "regardless of trouble," and applying this ointment, had no right whatever to infer anything as regards the share taken by his constitutional measures. I must admit that it is even possible that he might obtain an apparent and temporary cure of a case of favus. It is a point which we may mention with much satisfaction that we have during the last half-century advanced to a clear knowledge that all the maladies mentioned are for the most part, and usually altogether, local: but although we have added some important remedies to our pharmacopœia, we still have possibly none which are more useful than that with which Mr. Macilwain inadvertently cured his patients.

The word *gout* is one which we are apt to believe has

always had one and the same meaning. I much doubt, however, whether it was not by some persons and in some places in former days used as a name for rheumatism. In the records of the Kilmarnock Registrar, from which I have several times quoted, I have observed a number of entries which state that the cause of death was "gout." Thus, Elizabeth Gray, aged 40, wife of a thatcher, died of "gout"; and Marion Richmond, a young woman only 22, the daughter of a bonnet-maker, was also registered as having died of "gout." Now gout is supposed to have been very rare in Scotland, but, whether common or not, it is almost incredible that persons of these ages, and in these stations of life, should have died of it. In all probability, it is acute rheumatism that is meant. I do not think, however, that true gout was so entirely unknown in Scotland as some authors would have us to believe, for Sir Walter Scott, who was an authority, repeatedly mentions it, and in connection with wine-drinking habits.\* It may be added that in the Kilmarnock Register by far the greater proportion of those alleged to have "died of gout" were women.

It is, I suppose, generally known by English surgeons that on the Continent the word "Struma" means Bronchocele. It was so used in England formerly, and such is its meaning in the quotation which I gave at page 384 of Vol. IV. So also in France "Nævus" means any form of Mole.

No. CXVIII.—*Gouty Phlebitis—Recovery after Obstructive Thrombosis and suspected displacement of clots.*

The danger of detachments of fibrinous clots in the course of phlebitis is well known. It is not, however, an event which is frequently encountered in practice. When it occurs, and when the clot finds its way to the heart, it is probably almost invariably fatal. Mr. Skey has published the details

\* The word "gout" is supposed to be derived from the French, *goutte*, a drop, and that, in turn, from the Latin, *gutta*. Shakespeare mentions "gouts of blood." It is, therefore, applicable to any disease which might be considered due to "defluxion."

of one such case, and the late Dr. Ormerod, of Brighton, many years ago showed me an excellent specimen of a clot entangled in the valves of the heart in the Museum of the Sussex County Hospital. I have never myself known a case in which this accident was supposed to have occurred and in which the patient recovered. One such, however, has been reported to me under circumstances more or less trustworthy. A gentleman aged 38, of gouty history and large veins, was confined for nearly six months to his bed by obstructive phlebitis in the right lower extremity. He told me that on two occasions during this illness he had very nearly died with extreme difficulty of breathing and pain at his heart, and that his medical attendant had diagnosed a detached clot. It was probable that the deep veins of the limb had been affected, for his legs remained afterwards liable to œdema. Considering the great frequency of obstructive phlebitis of superficial veins and the extreme rarity of these accidents, we may probably assume that there is not much danger when they alone are involved. Many gouty persons suffer from repeated attacks of this affection, and are by no means careful to observe the recumbent posture during any long periods.

No. CXIX.—*Purulent Phlebitis implicating cavernous sinuses.*

Case XII., in Dr. Bright's second volume, is a good example of inflammation of bone from injury, suppuration of diploe and between bone and dura mater, extension backwards to both cavernous sinuses, and finally to subarachnoid spaces at base of brain. The patient, a man of middle age, who had been kicked by a horse, had left the hospital, but returned very ill the same evening. He died three days after the return to hospital and twenty-four after the accident. The veins in one orbit and some also in the brain were full of pus (see p. 34).

No. CXX.—*Extensive denudation-areas around optic discs, independent of Myopia and of over-use.*

An interesting example of extensive choroidal denudation around the optic disc, exactly like that of advanced myopia,

but without any material elongation of the globe, came under my notice in an old man of 72, from Yorkshire. Although he had managed to make a moderate fortune, he had never learned to read, and his eyes had never been employed upon near objects. In early life he was a sailor, and more recently a coal merchant. He assured me that, when he went to sea, he could see in the distance as well as any one. Of late his sight had failed very much. It was difficult to estimate his vision accurately; but it was certain that nothing higher than  $-2 D$  improved him in the distance, and that with this glass he could only make out about  $\frac{1}{8}$ . The two eyes were alike. In both there was a very large arcus senilis, and in both a most deceptive appearance of opacity of the lens. From an unaided inspection of the eyes I had written down "cataracts in both"; but, to my surprise, on using the ophthalmoscope I found I could see all the details of the fundus without the slightest obstruction. Finding an area of complete denudation, very abruptly margined and completely surrounding the disc, which was nowhere less than two or three times the width of the disc itself, I supposed that we had to do with high myopia, but, on testing this, found that it was very slight and, as already stated, not more than  $-2 D$ . I was so much surprised at this result that I asked my son to measure the myopia carefully. This was done with the same results which I had myself obtained. In each eye there was a group of fine pigment spots at the yellow-spot region; and to senile degeneration in this part, it appeared probable that his defect in vision was chiefly due. There was also a little haze in each lens, although, as stated, not enough to prevent a perfect inspection of the details of the fundus.

No. CXXI.—*Rupture of Muscle simulating a tumour*  
*— Remarkable instance of erroneous history given*  
*by patient.*

Colonel C. — was sent to me on account of a tumour which was supposed to be growing in the front of his thigh. He was a stout, robust man, aged 60. In the middle of the front of his right thigh there was a lump about as large as



half a small orange, which was evidently attached to the quadriceps muscle. It was ill-defined, but of considerable hardness. It had been doubted whether it were attached to the bone or not, but on this point I felt no doubt that it certainly moved with the muscle. I was struck with the fact that there seemed to be a hollow in the middle of the quadriceps just below the swelling, and, thinking that the latter might be consequent on rupture of the muscle, I inquired as to any accident. This my patient, who was a very intelligent man, entirely denied. He had, he said, discovered the lump almost by chance about a month ago. Under these circumstances I advised him that he should have the swelling explored by an incision, and freely excised if it should seem desirable. The next day, however, I received a letter informing me that he had remembered an accident of considerable severity which had happened about six months ago. He had slipped down a flight of five steps in his garden when they were covered with ice. He wrote, "I thought I had broken my leg, and it was several minutes before I could get up. I was then lame for several days, but gradually got better." On learning this, I requested another visit before sanctioning an ~~excision~~ <sup>exploration</sup>. On a more careful examination I convinced myself that the swelling really was the stump of a ruptured rectus muscle. It moved with all movements of the muscle, and there was a very distinct trough of considerable size extending down the middle of the thigh immediately below it. It is needless to say that I advised that, for the present at least, all thought of operation should be given up. H/n/

It is not the first time that I have known the contracted end of a torn muscle assume conditions which led to the suspicion of a tumour, but I have never before known a patient entirely forget the history of the accident which had caused it. In this instance the patient admitted that, after his fall, he had to be carried into his house, that he was confined to his couch for several days, and that he had been lame ever since; yet in the hurry of the moment, when the question was first asked, he had forgotten all about the occurrence. It may be added, in explanation, that he was

a man whose thoughts were constantly occupied by very important engagements. The case adds another to the numerous, and frequently repeated, instances which warn us of the danger of trusting to the impromptu statements of patients. Always ask again after time for reflection has elapsed.

No. CXXII.—*An exceptional form of Dupuytren's Contraction.*

Different examples of Dupuytren's contraction of the palmar fascia present, occasionally, very remarkable features and special peculiarities. In a gentleman, whom I saw a few weeks ago, the contraction was strictly limited to the little finger of each hand, which was drawn down until its tip touched the palm. He could straighten his ring fingers perfectly, and I could not detect any induration of the fascia in the palm itself. There could not have been a more conclusive demonstration of the now well-known fact that the tendons are in no way affected. The condition was most precisely symmetrical. The contraction was caused chiefly by a single strong band from the ulnar border of the finger, which passed from its base to near its tip. There was no history of tendency to this malady in his family, but the patient was of a gouty stock, and had himself, on a single occasion, had an attack of gout.

It is of great interest that in these aberrant forms we see the condition developed with exact symmetry. In such a case as the above we can attribute nothing whatever to local influences. The patient had used neither tools nor playthings; nor, if he had, would it have been likely that both hands would have been affected alike. What the constitutional influence may be which sets this contraction of fascia going, it is very difficult to say. That it is in some way connected with the hereditary tendency to gout, and in an especial manner with hereditary tendency to itself there can be little doubt. Yet, as regards gout, we may freely acknowledge that it does not mean a direct manifestation, but is connected only as a sort of offshoot, having its analogues in forms of tissue change which are undomestically asso-

ciated with hereditary gout, but not with lithiasis or tendency to the formation of tophi. The almost absolute exemption of the female sex is a very remarkable feature.

No. CXXIII.—*Case illustrating prognosis in Heart Disease.*

A case of some interest in reference to the prognosis of heart disease came under my observation in connection with a form of chronic eczema on the extremities. A railway inspector, aged 50, in good health, consulted me concerning the state of his hands. He had scaly, thickened, and peeling patches in the palms of both hands and between his fingers, and some red patches on both legs. On the latter positions the disease had been present for nearly two years, and everywhere there was some tendency to papillary growth and thickening. The patches on his hands had appeared only within the last nine months. The chief interest of his case, however, concerned the state of his heart. His heart was much hypertrophied in connection with obstructive valvular disease. There was no history of special cause, for he said that he had never had rheumatism. The disease had been recognised from youth, and at the age of seventeen he had been taken to Sir William Gull for advice. He himself attributed it to his having in early life been accustomed to run to trains, &c. He said that he had often sat in the railway carriage panting for twenty minutes before he could recover his breath. His life had been refused at no fewer than six different insurance offices, and, although he had always been able to continue his active occupation, he had consulted many physicians. For many years he had been in the habit of carrying nitrite of amyl about with him, and he had formerly suffered severe and protracted attacks of angina. For two years past he had been quite free from these attacks. His immunity coincided with the appearance of his eczema.

No. CXXIV.—*Inflammation of Submaxillary Gland*  
—*Suspected Calculus.*

A man, aged about 40, apparently in good health, was sent to me with a considerable swelling of his right submaxillary

gland. It had given rise to suspicion of a new growth. Along the floor of his mouth there was considerable swelling, and Wharton's duct appeared to be much thickened. I thought that I could detect a calculus in it, and my son, who was with me, shared the impression. The swelling had been present for some weeks. I made a very free incision along the course of Wharton's duct into the indurated structures, and, although at first I thought I had struck a mortary concretion, I was in the end obliged to abandon the search, being unable to remove a calculus. The result, however, was quite satisfactory. When the man came up to me ten days later the swelling had very much subsided; and two or three weeks later still I heard from his surgeon that it was not necessary for him to come up again, as the swelling of the gland had quite disappeared.

I have repeatedly removed calculi from Wharton's duct in cases of inflammatory engorgement of the submaxillary glands, but I never had one in which the relief was so definite and so prompt as in this case; yet it is difficult to see how the incision should by itself have done much to give relief. The question remains whether the calculus did really escape and was lost. Although this is possible, I confess that I do not think that such was the case. Whether or not, the case still strongly supports the surgical view to make an incision whenever there is any suspicion of the presence of a calculus. Had I not felt too confident in my diagnosis, I should have passed a probe down the duct and sounded for the calculus before using the knife. In any case it is wise to take this precaution. I have more than once detected calculi by sounding, not only in the submaxillary but in the parotid gland.

No. CXXV.—*On partnership Causation in reference to the Eruption known as Urticaria pigmentosa.*

Another excellent example of successful results from the investigation of disease after the manner that I have recommended is offered by the disease known as urticaria pigmentosa. I hope that I am guilty of no misrepresentation of

the present creed of our best dermatologists if I say that this malady exists for them as a very rare and, as regards cause, quite mysterious one. It is possible that some may have called it *sui generis*. The student of combinations is not, however, satisfied with a bare diagnosis and a name. His process of reasoning is somewhat as follows: First, he avails himself of the well-known fact that an urticarious wheal may, in quite healthy persons, result from various forms of local irritation, nettle-stings, flea-bites, &c. Secondly, he calls to his aid the fact that the skins of young persons develop the urticarious wheal very easily and freely. Thirdly, he remembers that urticarious susceptibility to local irritation varies very much in different individuals, and that in some it is so excessive as to amount almost to an idiosyncrasy. A fourth consideration is, that under the laws of pathological habit certain influences of transitory duration tend, if frequently repeated, to produce more or less lasting results. Fifthly, as regards pigmentation he gives attention to the circumstance that the readiness to deposit pigment in the tissues is often a peculiarity of the individual, having relation to his complexion, &c., whilst in all persons long-continued irritation and frequent congestion of the skin is sure to lead to it in some degree. Sixthly, certain persons, especially certain children, are beyond all their companions attractive to fleas, gnats, bugs, &c., and liable to suffer from their attacks. These six postulates having been granted, we are almost in a position to foretell the occasional development of such a condition of skin as that under investigation. Given a child attractive to fleas, very prone to urticarious dermatitis, with much movable pigment in the blood, and what is more probable than that his flea-bite urticaria should become persistent and his skin brown? The picture may be made yet more complete by supposing that the child scratches without control, and that he is under circumstances which expose him in an especial manner to the attacks of parasites, whilst but little has been done for his protection.

Those who demur to the theory of external irritation being the exciting cause of urticaria pigmentosa, suggest with

truth that there are thousands of flea-bitten children who never develop this condition, that fleas are very common and this malady very rare, that fleas in the majority cause no urticaria at all, and there is in the subjects of the malady usually no clear proof of unusual exposure to the supposed cause. All these objections are due to forgetfulness of the laws of partnership. It is most true that amongst the children of the poor it is very common to see the skin speckled over with the little petechiæ left by flea-bites without the slightest trace of urticaria. In these, one element in the partnership—the proneness to urticarious inflammation—is absent. If it were, not that the coming together in the same child of the several peculiarities which have been named were a very rare coincidence, urticaria pigmentosa would be far commoner than it is.

This hypothesis, of a seldom-occurring combination of certain individual peculiarities with local irritation as the cause of urticaria pigmentosa, may be submitted to tests of its probability. If it be the correct explanation we ought to expect half-developments of the malady—cases, to wit, in which some of the elements of partnership are omitted; we ought also to encounter ill-marked examples of it, and those ought perhaps to be more common than the extreme ones, and we ought to find that the malady itself ends when the conditions terminate. Now each one of these propositions is true. We do meet with not a few children whose skins are more or less pigmented and thickened from frequently recurring local irritation, but in whom the malady never attains the dignity of a name. We do also see some children who suffer terribly from flea-bite urticaria, but who never become pigmented. We do find that urticaria pigmentosa ceases as a rule when the child, by advancing years, becomes no longer so attractive to fleas, nor so liable to urticaria from irritation. We have further its precise analogue in adult life, and especially in senility, in which, from the irritation of body-lice and scratching, the whole integument may, in exceptional cases, become thickened, harsh, and almost black with pigment. What *Melasma a pediculis* is for the old man (see Hebra's portrait), urticaria pigmentosa

is for the child. There is no mystery about the causation of either. Each is in turn the result of a combination of causes, which are severally easy of recognition.

No. CXXVI.—*Operations for Hernia two centuries ago.*

From Cooke's "Marrow of Chirurgery," fourth edition (1685), which may be held to represent the state of English Surgery in his day, the following is an extract:—

"OF CUTTING FOR RUPTURES.—This operation is seldom used because hazardous and dreadful. 'Tis performed, either when what is fallen into Scrotum cannot be reduc'd, or to hinder their falling and so to cure, in both which the party is to be first tyed fast to a Form or Table. In the *First*, when the Guts cannot be reduced, either from the hard'n'd *Fæces* there, or the narrowness of the passage; make the incision in the upper part of the Scrotum, not touching the Guts, then with the *Directory* put in at the Incision and under the production of the peritoneum with your Knife cut so much as is necessary towards the Belly. After Reduction stitch up so much of the *Peritoneum* as may suffice to hinder the fall of anything into Scrotum after it is cicatriz'd. But perform not this, unless strength be sufficient, much less what follows."

Cooke then proceeds to describe the operation for radical cure in non-strangulated cases. It will be observed that he does not mention any other form of hernia than inguinal, and that when operating for strangulation he clearly contemplated obliteration of the sac.

No. CXXVII.—*Dupuytren on Early Operations for Hernia.*

I extract the following from an account of the improvements in surgical practice which had been recently effected at the Hotel Dieu, communicated by Dupuytren to Dr. Ratier. It refers to the first quarter of the present century: "Hernia are now operated upon, so soon as patients enter the hospital. . . . The number of deaths (from all causes) has

diminished, it is one in eighteen, nineteen, or twenty in common years; the operation of lithotomy succeeds in five-sixths, that for hernia in three-fifths, that for cataract in seven-eighths," &c., &c.

No. CXXVIII.—*An example of temporary Xerostomia.*

As a rule, xerostomia, when once developed, is permanent; or, if it undergoes any amelioration, it is only partial, and after the duration of some years. As a rule, also, xerostomia occurs only in women. A gentleman who consulted me, about a year ago, on account of sciatica, afforded, however, an exception to both these statements. Unfortunately I have only his own description of his symptoms, and it is quite possible that there may be some fallacy in his narrative. He stated that he had had an attack of dry mouth, which lasted one month, during which his tongue was swollen, and the whole of his mouth so dry that he was obliged to occupy himself constantly in sipping water or sucking ice. Previously to this occurrence he had been accustomed to a very moist mouth, and the condition, when I saw him, was perfectly normal. The attack passed off spontaneously.

No. CXXIX.—*Profuse Perspiration as a symptom.*

A young gentleman, who was about to be married, called to consult me in reference to that event. I had treated him for syphilis three years previously; but, as he had remained perfectly well ever since the disappearance of the secondary symptoms, there was no reason to suspect that he was in any degree under the influence of taint. During the last two years he had taken no medicine, and had not had a symptom. He had up to quite recently enjoyed excellent health, and had been accustomed to take a great deal of exercise—rowing, hunting, &c. The arrangements for his marriage had entailed a great deal of business trouble. One of his near relatives had been very ill, and he had also been anxious, in reference to his old syphilis, as to whether he was doing right to marry. Under this combination of depressing conditions



he had become very weak, his special symptom being a remarkable proneness to perspire. He told me that if he had to write a letter on any matter involving responsibility, it would cause him to break out into a most profuse perspiration, that the slightest exertion would make him sweat, and that in bed he would often lie awake for hours together with his nightshirt soaked. I asked him if he were suffering from sexual irritability or emissions, and he replied, "Oh dear no, I am far too weak for that." Yet, in spite of his sense of extreme lassitude, I could not detect any indication whatever of disease, and he was in good spirits, and not in the least nervous. He assured me that his symptoms had come on quite recently, and that they were due to the causes mentioned. He also felt confident (after my assurance that his syphilis was a thing of the past) that he would, when the worry of his marriage was well over, soon regain his tone. It is as an example of functional disturbance of the perspiratory glands, reaching an unusually high degree, that his case has its chief interest.

No. CXXX.—*Good Health in a man the subject of inherited Syphilis.*

A case of some interest, as illustrating the assertion long ago made that those who recover from hereditary syphilis in infancy often display no tendency whatever to chronic ill-health, came under my observation a few weeks ago. The patient was a gentleman aged twenty-six, whom I had treated in infancy for syphilis. He got well, and remained so until December, 1877, when he was sent to me with an attack of severe keratitis. I prescribed iodide of potassium and grey powder, and saw him only once. When he came to me recently he brought the letter, which I had written to his surgeon in 1877, from which I extract the following expressions. "I fear the keratitis will be very troublesome; it is severe, and will prove a long attack. If it is gone in three or four months he must be well content."

The recovery of his eyes was almost perfect. When I saw him the other day he could, making an allowance for myopia,

see quite well. His left pupil was very large, possibly from the too free use of atropine during the attack ; but the mydriasis was not attended by any loss of accommodation. He told me that his eyes had recovered in about the time that I had led him to expect, and that during the sixteen years which had since elapsed he had never ailed anything. It is remarkable that neither his physiognomy nor his teeth showed anything suspicious, and, had I not been previously acquainted with his history, I might have felt it difficult to believe that he was the subject of taint. A sister, six years older than himself—the only other living child—had also suffered from inflammation of her eyes ; but was now in good health.

No. CXXXI.—*Obstruction of the Long Saphena Vein by enlarged glands.*

The following narrative may be read in connection with what I have written at page 163 against trouser-pockets :—

I saw, with Mr. Garry Simpson, at East Acton, a young man of 22, who was supposed to have phlebitis of the long saphena vein in the whole of its course. I was told that the vein could be easily traced by the finger as a piece of thickish cord, beginning in Scarpa's triangle, and passing down to the ankle. The patient was in bed when I examined him, and I was at first disappointed that I could not find what had been described to me. Only with difficulty could I detect the vein at all with the finger, though a greenish streak on the inner side of the thigh made its position quite apparent to sight. The patient suggested that he should stand up, assuring me that I should find it easily then. This proved to be the case. In the erect position I could trace the vein through the whole length of the limb. It felt as if about the size of a cedar pencil, but it was not very hard. Nothing in the least like it could be discovered in the opposite limb. Our patient was suffering from an acute gonorrhœa, and there were some enlarged glands below Poupart's ligament. It seemed probable that these compressed the vein at its point of entrance into the femoral, and thus prevented the return of blood. There was no reason to think that the femoral

itself was plugged, and there was no œdema of the limb. It did not seem probable, therefore, that any form of phlebitis had travelled from the pelvic organs. The vein had not been rendered in the least tortuous, but I had little doubt that its coats were somewhat thickened, for it certainly was much firmer than natural. There was besides a distinct greenish tinge over its course.

No. CXXXII.—*A doubtful Diagnosis of Ringworm of the Nails.*

In July, 1887, I treated a girl of 17, for what we then diagnosed as eczema of the nails. The history was that in infancy she had eczema of the scalp ("with a big crust"), and at that time one finger-nail had been all over little dots like pinpricks. When I saw her almost all the nails of both hands were affected, and were covered with little indurations, which were most numerous near the lunula. She had at this time no eczema of any other parts. I prescribed a bichloride wash, and gave arsenic internally, and a few months later changed the wash for a mercurial ointment. The chief interest of the case consists in the fact that six years later I learnt from her brother that the remedies prescribed had quite cured her, and that her nails had remained well, with the exception of what he described as a few little dots here and there. This brother came under my care himself on account of some scaly patches on the back of his neck and cheek, which he believed had resulted from ringworm eight years ago. He thought the sister had also suffered from ringworm, and at about the same time. It occurred to me as possible that what I had called eczema of the nails had really been ringworm.

## A CATECHISM OF SURGERY; WITH CASES FOR DIAGNOSIS.

No. CLXXVII.—*The Diagnosis of different forms  
of Hernia.*

### QUESTIONS.

1. Is it ever difficult to diagnose between inguinal and femoral hernia?
2. Is it important to make the diagnosis?
3. How would you best avoid mistakes?

### ANSWERS.

1. Yes, errors are very frequently committed, more especially in women, when a femoral hernia is of considerable size and turns up over Poupart's ligament. It is very seldom that an inguinal is mistaken for a femoral one.

2. It is very important in reference to the taxis, for the direction of pressure to reduce an inguinal hernia will entirely fail if it be femoral, and might do mischief. It matters less perhaps in the case of an operation, for the diagnosis will be rectified as it proceeds.

3. The first point is to notice whether the hernia passes in the case of a male into the scrotum, and in the case of a female into the labium. Femoral herniæ, however large, never take this direction, whilst inguinal herniæ, however small, generally show a definite tendency to it. In a man, the finger may be passed into the external ring by invaginating the scrotum, and in this way it may usually with ease be made clear whether or not the canal is occupied. If the hernia have curved over Poupart's ligament so as to conceal it, it should be gently drawn downwards, and then in nine cases out of ten it will be easily ascertained that its neck passes deeply under and not over the ligament.

No. CLXXVIII.—*Fungi attacking Plants, &c.*

## QUESTIONS.

1. Is it true that, when fungi attack living plants, those only that are already diseased are assailed?
2. Give instances in proof of the assertion that young and healthy plants may be attacked by parasitic fungi?
3. Mention a good example of a fungus which attacks only dead vegetable tissue.
4. Is it probable that the vegetable parasites which attack human beings can develop in those who are in perfect health?
5. Has the age of the individual anything to do with his proneness to suffer from vegetable parasites?

## ANSWERS.

1. Some fungi attack dead vegetable matter, but only immediately after its death; some that which has been long dead; some that in which the vitality has been lowered, and yet others that which is in perfect health.
2. You have but to observe a patch of vigorously growing groundsel (*Senecio vulgaris*); almost every plant that has attained the height of six inches will be found to be affected with fungus. The same is true of the smut in cornfields, which destroys the buds of plants in most luxuriant health. Numberless other instances might be given.
3. The dry rot is due to a fungus, which spreads with extraordinary rapidity in wood which has been long absolutely dead, and has been placed under certain conditions as regards the exclusion of air. Many moulds, &c., grow only in dead tissues.
4. The fungi which cause ringworm, favus, &c., will attack the most healthy individuals. When very extensive, they may cause ill-health, and thus lead to the erroneous supposition that the patient was out of health before he was attacked.
5. It would appear that very young infants are but little liable to be attacked by the fungus of ringworm or favus. It is only when the hair has attained a certain stage of growth, but still remains succulent and soft, that the ringworm fungus

can flourish in it. The epidermis becomes liable to be attacked by the fungus of pityriasis versicolor at a later period of life, and the liability persists much longer. As senility approaches, the tissues appear to become for the most part, if not wholly, exempt from the invasion of parasitic fungi.

### No. CLXXIX.—*Xerodermia.*

#### QUESTIONS.

1. Under what names was the condition known as "Xerodermia" formerly recognised?
2. Is it always a congenital disease?
3. What are the anatomical peculiarities of the skin?
4. Are those who suffer from xerodermia liable to other special affections of the skin?
5. Is there such a condition as functional xerodermia?

#### ANSWERS.

1. The term "ichthyosis," with one or other appended adjective, such as simplex, serpentina, vera, and many others, was usually applied to the disease which is now usually known as xerodermia. The latter term ought to be restricted to those forms which are universal, and attended with general dryness and inability to perspire.

2. The best marked cases are always congenital, and usually several members of the same family are affected.

3. It is probable, though it has scarcely been yet proved, that the development both of sebaceous and sudoriferous glands is defective, and that with this goes some imperfection in the formation of the rete.

4. Patients who are the subjects of congenital xerodermia are very liable to peculiar forms of eczema and prurigo. Their inability to sweat often entails great discomfort.

5. The term functional xerodermia may be suitably applied to cases in which inability to perspire comes on in a patient who has formerly enjoyed a perfectly healthy skin. It is not unfrequently associated with senility, and it is sometimes seen in young or middle-aged persons in connection with nervous disturbance. It is seldom absolute.

No. CLXXX.—*Xerostomia*.

## QUESTIONS.

1. What is the meaning of "xero" as used in the names of diseases? and to what affections can it be applied?
2. What are the clinical features of the disease which has been named xerostomia?
3. Is it a curable disease?
4. In which sex is it most common?
5. What drug has been found most useful, and what are its drawbacks?
6. Is xerostomia usually attended by other indications of nervous disease?
7. In protracted cases is it followed by failure of general health?

## ANSWERS.

1. It means simply "dry"; and is applicable to any disease attended by abnormal dryness of the affected surface, whether skin or mucous membrane. We have xerophthalmia, xeroderma, and xerostomia.
2. Transitory conditions of dry mouth are, of course, very common in connection with nervousness; but the term "xerostomia" is reserved for certain rare cases, in which the condition is protracted, if not permanent. The whole of the mouth is involved, lips, cheeks, tongue, palate, and even pharynx. No flow of saliva takes place during eating, and the patient is obliged to sip fluids in order to swallow her food.
3. So far as at present known, it is incurable; but in the course of years it may undergo some mitigation.
4. It is almost exclusively met with in the female sex, and usually in those beyond middle age.
5. Jaborandi, or its active principle, pilocarpine, will in some cases cause flow of saliva. Patients usually complain that, if used of efficient strength, it makes them feel very weak.
6. It is a very remarkable fact that there may be an absolute arrest of the salivary and mucous secretions of the mouth, without any other indication of disorder of the nervous

system. Most of the recorded cases have been in patients who were otherwise in fair health.

7. It is also a very remarkable fact that this arrest of salivary secretion may be protracted over years, without inducing any definite failure of health.

### No. CLXXXI.—*Xerophthalmia*.

#### QUESTIONS.

1. What is the meaning of the term "xerophthalmia"?
2. Under what conditions is dryness of the conjunctival sac met with.
3. What cases are comprised under the term "pemphigus of the conjunctiva"?
4. Is there any name for inability to shed tears? and under what conditions is it met with?
5. Is any influence of climate or occupation observed in this affection?

#### ANSWERS.

1. "Xerophthalmia" is a term which has been long applied to certain cases in which the whole front of the eyeball becomes quite and permanently dry. Not only is there no flow of tears, but there is no secretion of conjunctival mucus.

2. It is usually considered that some form of chronic ophthalmia precedes the condition of dryness, such, for instance, as that induced by long neglected entropion. It is certain, however, that in the great majority of cases of relapsing or persisting conjunctivitis, no tendency to xerophthalmia is ever produced. The worst and most typical forms of the latter are almost always in association with failure of health and some form of skin disease.

3. The condition known as "pemphigus of the conjunctiva" is a form of conjunctivitis in which the palpebral sac becomes obliterated and the whole conjunctiva dry. They constitute the most marked examples of xerophthalmia. Almost always there is some form of skin disease, allied to pemphigus; but it is seldom that the patient is the subject of a well-characterised form of the latter malady.

4. By some observers xerophthalmia is divided into lachrymal and conjunctival, the term lachrymal being employed



for those cases in which the action of the lachrymal gland only is suspended. These are probably common. Inability to shed tears is in part an attribute of sex, especially when it occurs solely in connection with the emotions. It is common in the insane, and may occur also after violent mental shocks. We may doubt whether any cases occur of conjunctival without lachrymal xerophthalmia.

5. The influence of climate and occupation is probably very important. Exposure of the eyes to the glare of the sun and to the irritation of sand may be very prejudicial in this direction; and furnace-men, bakers, cooks, and others, if the subjects of skin disease on the face—psoriasis, pemphigus, or eczema—may easily become the subjects of chronic conjunctivitis tending to xerophthalmia.

No. CLXXXII.—*Confusion of Mind in the Witness-box.*

QUESTIONS.

1. A medical witness in a railway action was asked whether he did not find it difficult to explain that the man had had his lower extremities quite paralysed whilst his sphincters had remained perfect. He replied, "No; there is no difficulty in that, for the legs are lower down than the trunk." Was his answer correct?

2. The same medical witness was asked whether his client had presented any objective symptoms, and replied gravely, after some consideration, "He had a severe pain in his back." Is pain an objective symptom?

ANSWERS.

1. No; it was founded on a misconception. We have but to think of a quadruped instead of a biped to see at once that the tail and its adjuncts are really distally placed as regards the lower extremities. With the tail go the genito-urinary apparatus and the lower bowel.

2. Pain is a type of a subjective symptom, since it can be appreciated only by the patient. When, however, the proofs of its existence become obvious to others beyond dispute, it may, perhaps, be allowed to rank as objective.

No. CLXXXIII.—*Questions without Answers.*

Is it possible to have syphilis twice?

Is the period of incubation in hydrophobia a definite one?

What is paludism?

What are Laveran's corpuscles?

How long a period of isolation should be required in the case of a person who has been exposed to risk of contagion of small-pox?

If a patient has been admitted into a small-pox hospital under a mistaken diagnosis, what ought to be done?

In a case of deafness, what is proved by the fact that the patient hears a watch well on his forehead?

What special risk attends the instillation of atropine drops into the eye?

Do Jewish circumcisors use stitches?

Is there much difference in the progress of the pock after vaccination as compared with that after inoculation with small-pox matter?

What is the incubation period of chicken-pox?

Are phosphatic calculi common?

*Addendum to paper on Jaundice by Suppression*  
(see page 122).

Dr. Francis Delafield, in a paper read two years ago before the Practitioners' Society at New York, expressed the opinion that fatal cases of jaundice without any trace of duct-obstruction were not very uncommon. He described them as having a duration of from three weeks to four months, and said that it was usual to find the bile-ducts and gall-bladder empty, and the liver itself large and bile-stained. He expressly denies, apparently as the result of careful post-mortem examinations, that there is in these cases any evidence of inflammation of the duodenum or common duct. He describes the course of the jaundice as being exactly that of common jaundice, popularly known as "catarrhal," and states that the patient may have had two or more attacks before the fatal one.\*

\* Dr. Delafield's paper has come to my knowledge too late to allow of my putting this reference to it in its proper place at page 122.

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PHYSICAL ILLUSTRATIONS  
OF THE ATLAS



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## PLATES XCVI. & CI.

### NÆVUS OF FACE CURED BY CAUTERISATION.



My favourite method for the treatment of nævi on the face, and in all positions where the avoidance of scar is important, is by the repeated use of the actual cautery. These two portraits show the condition of the same child before treatment and after cure by this means. I may assure the reader that there is not the slightest exaggeration in the second one. The cautery (Paquelin's) had been used repeatedly at intervals of about two months.





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# ARCHIVES OF SURGERY.

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JANUARY, 1894.

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## THE TREATMENT OF STRANGULATED HERNIA.

*(Continued from page 183.)*

My readers will have assumed from what I wrote in my last number that I am an apologist for the Taxis. A careful examination of the recorded results of the treatment forty years ago and that of the present time has impressed me strongly with the belief that a patient in whom a hernia had become strangulated, had formerly a far better chance of survival than he has now. This is a serious and somewhat humiliating admission. The chief change which has taken place has been consequent on disparagement of the taxis, and a refusal to believe that the operation has in itself any dangers. As the subject is one full of difficulty, and as great care is needed in order to avoid error in marshalling the facts, I shall perhaps consult the convenience of all if I attempt to find answers to a few explicit questions.

1. What was the ratio of fatality of strangulated hernia in former times?
2. What is it now?
3. Does the taxis increase the dangers of the case? and if so, how?
4. Does an operation in itself involve any increase of risk?
5. In what proportion of cases ought we to expect to succeed by taxis?

In seeking answers to the first two of these questions

is necessary to assert that we must ascertain the fatality of strangulated hernia and not of herniotomy. It is most unfair to compare the results of different surgeons, or of different periods, by formulating the statistics of operations only. We must take for our calculations all cases in which strangulation existed. In hospital practice it is not very difficult to define "strangulation," and probably the cases admitted with that diagnosis into the wards of our hospitals are fairly comparable. If a hernia-case is brought to a hospital, the house-surgeon, supposing it to be not a severe one, makes an examination and a brief attempt at taxis. If he succeeds, the patient probably returns home, and if otherwise, is sent into the ward. Some difference may obtain at different institutions in the degree of zeal, as to taxis, shown by the house-surgeon. If almost all cases are admitted, the surgeon will have a certain number of milder, and more easily recoverable, cases to treat than he would otherwise obtain. We will assume, however, that in the admission books and statistical reports of our various hospitals, the term "strangulated hernia" means pretty much the same thing—that it designates a case of hernia in which a first attempt at taxis, by some one, has failed, and in which there is more or less tendency to sickness.

Now it is, as just stated, quite obvious that we must take the total of all these cases into consideration in our attempts to estimate the success of different methods of treatment. Supposing two surgeons, the one a taxist and the other not, to have each under his care twenty patients with strangulated hernia, the one might reduce fifteen and operate on five, while the other might reduce five and operate on fifteen. The taxist might afford to lose every one of his operations and yet have on the whole better statistics than his colleague who had lost only half. Thus we see that it is most unfair to speak of a surgeon's herniotomy success as if it represented his success in the treatment of strangulated hernia. An excellent illustration of this is afforded by the records recently published by a veteran surgeon in a provincial city.

During the five years 1867 to 1871, Mr. L—— had at the Infirmary to which he is surgeon 8 operations for strangulated

hernia. Four were for inguinal hernia and 4 for femoral. There were 6 fatal cases, 2 inguinal and 4 femoral. Thus it appears that all the femoral cases operated on ended fatally (and in one, it may be remarked, the duration of strangulation had been only sixteen hours). There is no statement that in any of the cases in which an operation was done, the sac was not opened. Against what may appear to have been somewhat untoward results, we have to set the fact that during the period of hospital experience to which these statements refer, Mr. L—— succeeded by the taxis in 16 cases, and presumably all these cases recovered. Of these, 15 were cases of inguinal hernia. Thus it is probable that during this period Mr. L—— took much pains with the taxis. His results as regards inguinal hernia would appear to have been as follows. Nineteen patients came under his care with strangulated inguinal hernia, 4 being women and 15 men. Out of this number only two died, one man and one woman. The success was in the main due to the taxis, for 15 of the number were not operated on, and they all recovered.

It was needful to attempt a definition of the term "strangulation" before we could discuss the statistics of treatment of strangulated hernia. There is, however, no need to define *Herniotomy*, and it might at first sight seem to be an easy thing to construct statistics as regards operations for hernia, such as should admit of an easy comparison between different institutions and different modes of practice. As a matter of fact, however, it is exceedingly difficult to do so; and, as might easily be shown by citations of the statements of authors, such statistics might prove very misleading. Thus we have it on Mr. Fergusson's authority, that Mr. Luke, during the period that he was accustomed to open the sac, lost about one patient in every three on whom he operated, but that, after he changed his practice in this respect, out of nearly forty operations he lost only two. The difference between 1 in 3 and 1 in 20, and that on the authority of a man so trustworthy as the late Mr. Luke, might seem to be conclusive in favour of the new method; yet the operation without opening the sac can scarcely be said to have held its ground, and when the results

of practice at St. George's Hospital, where the sac was almost always opened, and at the London, where the endeavour was constantly made to avoid doing so, were compared, it was found that the balance was slightly in favour of the old method. No one can doubt that some error had crept in, in reference to Mr. Luke's statistics. No one familiar with the general conditions of hernia operations, however skilfully done, and by whatever method, can believe that it is possible that nineteen out of twenty of such patients can be saved. A much larger proportion than that are, from the very nature of the case, doomed to death before the operating surgeon is called in. I receive with like incredulity some statements as to successes, which have recently been reported in the English press from a Swedish source.

In the statistical fragments which I am about to quote, much will be left to the reader's own judgment. He must estimate the facts for himself, and make all due allowances for error. Only those well informed in details can use statistics to advantage.

In an able letter from the pen of Mr. Bowlby, which appeared in the *Lancet* a few months ago, and in which statistics collected by Mr. Berry were quoted, it was admitted that the present mortality of hernia operations, taking them all together, is not less than 43 per cent. These statistics are published by Mr. James Berry, in the St. Bartholomew's Hospital Reports for 1884, and are based on 940 cases, treated consecutively in St. Thomas's, Guy's, and St. Bartholomew's. In the same letter it is stated that Mr. Treves had admitted, respecting the London Hospital, that the recent average of mortality had been nearly 50 per cent. Mr. Bowlby succeeds in showing that at St. Bartholomew's during the last ten years the mortality did not quite reach 38 per cent., and I believe that Mr. Treves' statement was liable to a considerable reduction. Probably, however, we shall not be very far from the truth if we believe that at present in the London hospitals, the deaths after hernia operations amount to 40 per cent. At the present time, as I have said, early operations are the rule. No delay whatever is permitted after the patient comes under hospital care. In the

great majority of cases the sac is opened, under the now prevalent opinion that incision of the peritoneum does not increase the risk. Some form of antiseptic is probably used, either during the operation or afterwards, in most cases, and lastly, as an important addition to what was formerly done, we must note that, in a very considerable proportion of cases, the operator adopts measures for the radical cure by obliteration of the sac.

Mr. Southam has recorded for us the recent statistics at the Manchester Royal Infirmary. Taking the twelve years' period from 1881 to 1893, they are as follows. Total number, 85 cases, with a fatality of 44·7 per cent. The fatality in inguinal was nearly 39 per cent.; in femoral, 40·5; and in umbilical, 75.

A statistical table of operations at the London Hospital for sixteen months, October, 1860 to January, 1862, compiled by Dr. Woodman, shows that nearly one operation a week had occurred. The inguinal cases were nearly as frequent as the femoral. The gross mortality was 40 per cent.

In 1864, at the London Hospital, there were 27 operations for strangulated hernia, 13 for femoral, 10 for inguinal, 4 for umbilical. Twelve out of the 27 patients died. Seven of the cases were my own, and 3 of these were inguinal. The sac was not opened in 13 of the cases, and of these 5 died. In one case of inguinal hernia, which had been strangulated only five hours, and in which the taxis had scarcely been used, the patient died of peritonitis. He was a healthy young man of 28. In another case the strangulation had existed only two hours, and in a third only three hours. In neither of the two latter was the sac opened, and in both the patients recovered.

In 1865, at the London Hospital, there were 24 hernia operations, and the mortality was more than 40 per cent. Six of the cases were mine, 5 femoral and 1 inguinal. In 1866 there were 29 cases of strangulated hernia which required operation. Of these, no fewer than 18 were inguinal, and only 11 femoral. Eight of the operations were my own. I am glad to say that only one of these eight

was an inguinal hernia. These two years taken together give me 14 operations, and only 2 for the inguinal form. The year 1867 was a favourable year, for out of 20 operations only 5 patients died. There is no obvious explanation of this good result. Most of the cases had been strangulated several days, and in two only was the period less than twenty-four hours. There were 7 inguinal and 12 femoral, and 1 was a *reductio en masse*. The sac was not opened in ten of the cases, and the whole of these ten recovered.

In the year 1875, during which I did not operate at the London Hospital on one single case of strangulated hernia, 24 operations were done by my colleagues. Of these 14 died. Nine of the cases were inguinal, 14 femoral, and 1 umbilical. Of the femoral 11 died, and of the inguinal only 3.

The statistics compiled by my son for the London Hospital, during the years 1885 to 1889 inclusive (during which time he was Registrar), show a total of 100 operations. The fatality was 50 per cent.

In a paper published by Mr. Hancock in the *Lancet* for 1849, we have a large collection of cases from various authors with a view to determine average fatality. Most of the facts had been previously tabulated by Mr. Gay. The total shows a fatality of 32·5 per cent., the whole number of cases being 872.

During the present year Mr. Rushton Parker has recorded his personal experience of 49 cases, which gave precisely this same fatality, 32·5 per cent.

Mr. John Birkett, in a paper read before the Medical Society of London, recorded the results of 26 cases of femoral hernia under his own care. One half had terminated fatally. In 14 cases the sac was not opened, and Mr. Birkett expresses an unhesitating opinion in favour of what he calls the minimum operation, *i.e.*, not opening even the fascia propria. Of the fatal cases, in one strangulation had existed only eleven hours. Some of these cases were in private practice.

In a discussion on Mr. Birkett's paper, Mr. Hunt stated, in reference to the taxis, that he had never failed to succeed, and that on one occasion he had employed it continuously for

two hours and twenty minutes without intermission, and with success at last.

The following facts may help us to some estimation of the results at St. Thomas's Hospital twenty years ago.

In 1866 there were 16 herniotomies, with 7 deaths. The sac was opened in all excepting two ; 7 were for inguinal and 9 for femoral hernia.

The statistics for 1871 are so stated that it is extremely difficult to abstract them without risk of error.

The same remark applies to those of 1872 ; but it would appear that in this year, of 6 operations for inguinal hernia, 5 of the patients died, whilst of 7 for femoral only 1 died ; and that of 3 for umbilical 2 died.

In 1873 the total of operations was 14 ; 9 males and 5 females. Of these 8 recovered, and 6 died. No details are given.

In 1874 there were 16 operations, 10 males and 6 females ; 8 deaths and 8 recoveries.

In 1875 there were 21 operations, with 7 recoveries and 14 deaths. All the five patients operated on for inguinal hernia and the single one for umbilical died.

In speaking of the effects of delay and the effect of prolonged strangulation, Mr. Luke (the London Hospital) records the following facts. Of sixty-nine patients operated on within forty-eight hours, only twelve died ; of thirty-eight after the expiration of forty-eight hours fifteen died ; and of thirteen others, in whom the length of time was doubtful, six died. These cases comprise different methods of operating as regards opening the sac ; but were all in the hands of the same surgeon. They give a gross mortality of  $27\frac{1}{2}$  per cent. ; that is, not much more than one in four.

Still more extraordinary successes are recorded by Mr. Luke at p. 107, where he states that only two out of twenty operations for inguinal hernia died ; and only two out of thirty-one for femoral hernia. At the time that Mr. Luke was obtaining these extraordinary results it was, I believe, his invariable practice to give purgatives after the operation. Mr. Luke was a sober-minded man, not given to boasting, but it is impossible not to suspect that some fallacy underl

his statistics. At the present day (as I have already remarked) a larger percentage of cases come under the operator's care in a stage which is absolutely hopeless than Mr. Luke's whole mortality would cover. Part of his most unusual success must be attributed to the dexterity and care with which he performed his favourite operation. This explanation of his results cannot, however, be allowed to go very far.

In St. George's Hospital during the year 1865 there were 16 operations for strangulated hernia, the sac being opened in all but one. Eleven of the cases were for femoral hernia, 4 for inguinal, and one for umbilical. Eleven of the patients recovered. All the deaths were in cases of femoral hernia. In one of them, strangulated only for eighteen hours, it was expressly stated that the intestine was healthy. One patient had sharp secondary hemorrhage, and in another suppuration in the cellular tissue of the scrotum retarded the recovery. In a third, recovery was retarded by suppuration in the sac, and another is recorded to have died of exhaustion from profuse suppuration in the sac. I mention these facts in order to show that accidents attend herniotomy operations, which must not be forgotten by those who speak as if it had no dangers.

Before attempting to suggest any comparison of the results with those of former years, I must again ask attention to a fallacy to which I have already referred. It is this—that in proportion to the smallness of the number of cases of strangulated hernia reduced by the taxis ought to be the improvement in the ratio of recoveries after the operation. The success of an individual surgeon, or of a hospital, should always be calculated in reference to the total number of strangulated hernias coming under care. It is obvious that, if out of a hundred such cases one surgeon reduces fifty by the taxis, whilst another on principle almost wholly declines that method of treatment, and does not reduce more than five, that the success of the operations performed by the latter ought to be far better than that of the former.

The surgeon who thinks it his duty to succeed by taxis if he can, and uses it perseveringly and successfully, leaves only a residuum of the least hopeful cases for his operation-



statistics. This I must confess appears to me to be much the position in which the surgery of the present, as regards this operation, stands to that of the past. I am quite willing to believe that those surgeons who speak in disparagement of the taxis, and make it almost a boast that they never use it, are guilty of exaggeration, and do not do themselves justice. After making much allowance on this score, it is still probably true that a far smaller proportion of cases of strangulated hernia are reduced by the taxis now than was the case fifty years ago. It is not very easy to collect statistics to prove this, for but few surgeons have thought it worth while to record the number of their taxis successes. I have, however, been able to get a few items of evidence, which may help us to realise the truth.

The facts which I will next quote bear upon the questions as to—

*The danger which attaches to the Taxis, and the proportion of cases which may be so reduced.*

A statistical paper by Mr. W. Money records the experience of the Northampton General Infirmary from August, 1813 to August, 1814. A total of 157 patients applied on account of hernia. Of these, seven were strangulated—one femoral, and six inguinal. In not a single one was an operation required, and inferentially all reduced by taxis recovered.

During the year 1864, 67 patients applied at the London Hospital for hernias which could not be reduced at home. In 5 of these the house surgeons succeeded in reduction in the receiving-room, and the patient went home forthwith. Sixty-two were admitted to the wards. Of these, 35 were men, and 28 women. Only twenty-four out of the 62 were operated on; and of these, 11 died. There is no reason to believe that any of those in whom the hernia was reduced by taxis died, and the real fatality of strangulated hernia in this year is therefore not quite 1 in 6.

From Mr. Luke's paper in the thirty-first volume of the Medico-Chirurgical Transactions, I learn that, between the years 1842–47, 293 patients were admitted into the London Hospital with strangulated hernia. In 206 of these ~~tax~~

causes, and have noticed that the skin affection occurred as a substitute for some of the other more common catarrhal manifestations. We must not, however, expect much very definite evidence on this latter point from the patients themselves, since the dissimilarity of an affection of the skin from a cold in the head or an attack of sore throat will generally be sufficient to have prevented any suspicion of identity of cause. If there be affections of the skin which are catarrhal, we have for the most part overlooked their real nature ourselves, and we can scarcely expect that our patients should have observed it.

It will be observed that in the definition of catarrh which I have suggested, no importance is attached to the nature or quantity of the secretion attending a catarrhal inflammation. The definition depends upon the speciality of cause and course, and not peculiarity of result. It can lead, I think, only to confusion if we allow ourselves to apply the term catarrhal to all inflammations of mucous membranes attended by excess of secretion, since many of these have, as regards their cause, no relation whatever to the typical forms of catarrh. Nor must it be supposed that all catarrhal inflammations are affections of mucous membrane or are attended by secretion. The type of inflammatory action will vary according to the tissue which is affected, and may be plastic as in croup and pleurisy, mucous and watery as in a common cold in the head, or synovial in the case of rheumatic fever. In the instance of the skin we may expect it to take somewhat various forms, either merely congestive, attended with interstitial effusion, or with the formation of bullæ.

The diseases of the skin which I have to mention as constituting a catarrhal class, have, of course, not been overlooked by dermatologists. They have been well described, but have not been assigned to any special cause. Foremost amongst them is the malady vaguely known as erythema multiforme. The bullous eruption on the hands and feet for which many years ago I suggested the name of Cheiropompholyx, and which, as being liable to definite recurrence, I claimed as a neurosis, is probably another.

Some of the cases which have been called erythema iris, and some which have been named hydroa should also be thus grouped. Thrombotic Purpura, when it is recurrent after irregular intervals, may not improbably be catarrhal. Should it be objected that some of the maladies named are rheumatic, I must reply that in many instances the terms rheumatic and catarrhal are almost synonymous. Of the truly rheumatic affections, as distinct from gout and rheumatic gout, the same statements may be made as regards nature of cause, mode of manifestation, limited duration, and spontaneous recovery which I have suggested as the characteristics of catarrh. For me rheumatic fever is acute catarrhal arthritis. Bearing these facts in mind, I will now submit to the consideration of my readers the details of some cases of considerable interest in which I think that the diagnosis of catarrhal dermatitis may fairly be made.

CASE I.—*A recurring Catarrhal eruption on hands, feet, and ears, with Herpes of lips and symmetrical Herpes on the cheeks—Erythema Iris type of eruption.*

The case which follows seemed in a remarkable manner to mix the phenomena of the summer eruptions with those of cheiro-pompholyx and Raynaud's disease. The patient, Charles Drummond, was, when I first saw him, a lad of fourteen. The circulation in his extremities was very peculiar. His hands were dusky red and cold, and easily became stiff and blue when exposed. Bullæ had occurred on his hands and ears as in the "summer eruptions," but their occurrence did not appear to have been at all under the influence of weather. That the disease was constitutional and probably a neurosis of a somewhat different character to Raynaud's malady was shown by the occurrence of vesicles inside his cheeks, parts not much under the influence of external disturbances of the circulation. Further, it must be added that the disease followed the type of a recurring herpes or catarrhal malady, in always showing definite tendency to spontaneous cure. The longest attack he had ever had was not more than weeks, and some had been over in a week or ten day.

this tendency to spontaneous recovery and in its independence of weather the disease differed altogether from the "summer eruptions." The eruption when occurring on his feet had never affected his toes, but had occurred with symmetry on his heels. It is further to be noted, as possibly pointing to another alliance, that he had had threatenings of a patch on the fronts of both knees. The character of the eruption was very definite. It began as a little vesicle, which would burn and tingle, and at first contained fluid. The fluid was rapidly absorbed, and the epidermis again adhered, but the vesication would spread at its edge until a circle the size of a split pea, a sixpence, or a shilling, was produced. The amount of fluid under the slightly elevated edge was very little, and the epidermis everywhere adhered for a time. Thus no real bullæ were produced, nor any abraded surfaces. At the time that he came to me the palms of his hands were covered with little circles, which were quite flat except for a little elevation at their edges. The eruption was not attended by much swelling of the parts. When I saw him it affected the palms of the hands chiefly. There were, however, some abortive bullæ on the backs of the hands, and I was told that on former occasions it had often been abundant there. He was a lad of remarkably fair complexion and thin skin. His mother stated that in early life his hands used to get very hot, that he used often to mention that they were very hot, and she asserts that they used almost to burn her when he touched her. Suddenly, about three years ago, this ceased, and they became very cold. The liability to the eruption began three years ago.

The lad's mother had noticed that he looked bloated and puffy in the face before the eruption appeared, and was languid. He used also to frequently get a "hot lip." His mother had been accustomed to attribute the attacks to catching cold. The hot lip would always come first, and next a spot on his ear, and then some on the hands. He often at the onset complained of feeling cold and shivery. Thus it seemed clear that the attacks were of a catarrhal nature.

The following were the facts which were given me in regard to the history of his illness. He lived at Charlton, in Kent, on the chalk hills.

His first attack was in November, 1887. It began like "nettle-rash," and itched very much; the mouth also inflamed. He became ill, and was in bed for ten days. The doctor stated that his temperature was very high. The patient got very thin while in bed. For some time after he got up his appetite was bad, and he ate very little, but he gradually got well again. The skin eruption disappeared, and it was not till the following Easter that he had another attack.

This was the only time (in November) that he was ever confined to bed by an attack. The Easter attack began in the same way as the first, with itching spots on the hands and a few in the mouth. A small blister formed in both attacks on the rim of each ear. He was not on the second occasion seriously ill in himself.

The third attack was in August, and for this he went to the Stamford Street Hospital. It lasted about ten days, the eruption occurring chiefly in the hands. He had no further attacks during the winter, and it was not till the following spring that the eruption appeared again. This attack was about the same in severity as the present one. This was the only attack that year. The attacks this year have been in April, June, and August, and now for a fourth time in November. In the August attack the spots occurred only on the backs of the hands. He was then staying at the seaside. He found that as soon as he put his hands into sea-water they became stiff and cold. The lad states that his lip has always been the first part sore.

The above notes were taken in November, 1890. On November 14, 1890, I demonstrated the case before my post-graduate class. The lad was then in the stage of decline of an attack. Three days previously I had seen him with numerous vesicles with spreading edges on his fingers and palms. When brought before my class all the vesicles had dried up.

The patches in palms were of a dull brown tint, and peeling was about to commence in their centres. Some of them showed in the middle a little dull red point which marked the spot where the patch began.

He was a tall, well-grown lad, but pale and puffy. The sores inside the cheeks were healing just as herpes would. He could eat well.

I determined to try the effect of a long course of arsenic as a preventive remedy.

The date of my next seeing this lad was May 6, 1891, when he had taken with tolerable regularity for nearly six months three minims of Pearson's solution of arsenic, in bark, three times a day. The remedy had agreed well, and much im-

that on the day he came home from school ill he was very cold. The change of temperature that week had been one of the most extraordinary ever known, the difference by thermometer being between Wednesday and Saturday nearly 50°. The case, which was the subject of the New Sydenham Society's portrait, and which was definitely cured by arsenic, was probably of a somewhat similar nature. In the present instance the arsenical treatment which the boy has had for rather more than four months, though it has not absolutely prevented the attacks, has very much diminished their severity.

I did not see Drummond again until the spring of 1892. He had continued the arsenic in doses of five minims, and had had but one attack since his last visit to me, and it a very slight one, involving only the palms of the hands. He was no longer liable to any vesicles on his lips or ears, but these parts would sometimes smart if he came out of the cold into a warm room. He looked well.

A few weeks ago (Nov. 7, 1893), at my request, Drummond attended at one of my lectures at the Clinical Museum. I then read over the notes of his case, and showed three portraits illustrating conditions somewhat similar to those which he had formerly displayed. In himself there was nothing to be seen. He was now a tall, well-formed young man of seventeen. He stated that he had been quite free from attacks since I had last seen him, and that he had left off his arsenic. He considered that he was sometimes threatened when he took cold, but the eruption never developed. We may therefore consider him as now cured. Whether the arsenic is to be credited with his present immunity, or whether he has simply grown out of his liability, must be left an open question. I am inclined to believe that the drug has taken a definite share.

**CASE II.**—*Catarrhal attacks of Erythema, followed by peeling of the skin of the neck and hands—Patient a delicate man of middle age, liable to very profuse perspiration.*

The following case appears to be a good example of a recurring, symmetrical, erythematous eruption, in direct conn

tion with catarrhal causes. The patient's unusual liability to perspire probably exposed him much more frequently than others to chilling of the surface from damp underclothing.

Mr. H. W. H—, aged 47, of D—, came to me on November 12, 1890, with both hands peeling, and with the statement, "they always do so when I catch cold." The following are some of the facts which I elicited.

It was seven years since the first attack, which had occurred when he was in bed with congestion of the lungs. Although not definitely ill, he had never been strong. In 1872 he had a bad illness, and Sir W. Jenner visited him at D—. Rheumatism was diagnosed, with congestion of the lungs. He was once sent to the Engadine for his health. Any fatigue would bring on diarrhoea. He did not appear to have been unusually susceptible to catching cold, but still he often did so, and the attacks were severe.

The attacks were described as beginning by redness on the neck in a sort of collar, and then after a few days the hands also became red, and the epidermis would die and exfoliate. Transverse ridges across the nails always marked the dates of the attacks. His impression is that the attacks always follow "influenza colds." He is usually left very weak after an attack. Sometimes there is redness in the sides of the trunk, but no peeling follows there. Last September, two months ago, at Swanage, he had a bad attack, one of the worst he had ever had.

His attacks take about a fortnight, and the present one began a fortnight ago. He never before had two attacks so close together. He had always been a very free sweater; the slightest exercise would throw him into perspiration. He did not think that weather influenced the attacks. He suffered much from debility, but his circulation was good and extremities never cold.

I saw Mr. H— for a second time a month later. I had prescribed Pearson's solution of arsenic and tincture of belladonna, with cod-liver oil. It had made him dry in the mouth, and he had not therefore taken it quite regularly. He has *had no attacks of peeling* of hands, and has been better on the whole. Has been in better health, and has had no colds. He had a single spot of gangrenous herpes on his forehead, due, no doubt, to the arsenic.

CASE III.—*A recurring erythematous eruption on the hands and feet in definite association with catarrhal causes.*

Miss S—, a lady of 28, was the subject of a slight form of xerodermia. She gave the following interesting facts as to the catarrhal liabilities of her skin:—

"In winter, if I take cold and get a chill, the palms of my hands become red and my fingers tingle. The same occurs to my feet, and from my

palms and soles the redness soon spreads upon the legs and forearms. The redness and tingling last several hours, and then disappear almost wholly, but often come back again next morning. These attacks are always from taking cold, and I often have at the same time sneezing and headache. I am very liable to cold-catching, but if I have running at the nose I do not get the tingling of hands. An attack of ordinary nose cold usually lasts me much longer than one in which the limbs are affected. The causes of the two are, however, the same, such as going into cold rooms or exposure to draughts."

I asked Miss S—— to describe to me exactly what her sensations in her limbs were during an attack. She said it was "as if the whole hand or foot were involved in a chilblain, or had nettlerash, pricking and tingling all over." The parts always became crimson but never vesicated. She had in childhood suffered from what was called "nettlerash." It must be remembered that her skin was congenitally in a condition of slight ichthyosis, which probably explains the absence of vesications. Her skin was, she said, always more irritable when the weather was either very hot or very cold. She disliked extremes.

CASE IV.—*A recurring eruption on the hands, possibly of catarrhal nature.*

My friend Dr. C——, aged about 50, consulted me in March, 1867, on account of a curious eruption from which he had suffered on three previous occasions, and which had always disappeared spontaneously after about a fortnight's duration. He considered that the attacks had been attended by some slight symptoms of deranged digestion, but there had been nothing very definite in this respect. As a rule, he had enjoyed good health. The eruption had always appeared on the backs of his hands, but on the present occasion it had shown itself also on the face. When I saw Dr. C——, his face and the backs of both hands were covered by an eruption exactly resembling that figured by Hebra under the name of *Herpes iris*. Some of the patches were as large as a fourpenny-bit, and had raised edges and flattened centres; others were not larger than half peas. None of them presented any actual vesication, but they all looked as if just about to pass into the stage of effusion (abortive vesicles). Dr. C——'s attacks had occurred at intervals of a few months.



CASE V.—*Symmetrical eruption of Erythema patches with abortive vesicles on cheeks, backs of hands, &c.—Patient a young boy in good health—A first attack.*

I much regret that my notes of the following case do not enable me to do more than describe the first attack of what was not improbably a recurring malady. I possess a portrait of the boy.

On March 19, 1872, Mr. Tay sent to me a lad whose case presented some very interesting features. The eruption had come out suddenly, three days before, on his cheeks and the backs of both hands. Subsequently groups of spots had covered both ears, and had also shown themselves on the lips and on the neck, in the latter positions only sparingly. During the last day symmetrical patches had appeared on the inner sides of the knee joints. Thus the symmetrical arrangement and preference for peculiar positions was very marked. The rash consisted of groups, irregular in shape, of abortive vesicles, with much surrounding erythema. They were not shaped like the groups of herpes, but most of them were nearly round. On the margin of prolabium of upper lip were some, however, not distinguishable from herpes. None had as yet formed any fluid.

His mother reported that "every morning it was much worse, spreading fast." She could assign no cause. The lad was in good health, and had not in the least lost his appetite. The rash was reported by the boy to itch a good deal, but it had not kept him awake at night.

The boy's name was George Flynn, æt. 8.

CASE VI.—*A Vesicating Eruption on the hands—Relapsing through thirty years—Occurring in no other parts, and usually undergoing spontaneous cure.*

On December 13, 1867, a married woman, apparently in good health, attended on account of an eruption in the palms of the hands and between the fingers. The eruption showed large vesications, some of them as large as shillings, and with a certain amount of inflammatory swelling of the whole hand, back and front. The vesications would usually quickly break and dry up, leaving large denuded patches. In the palms of the hands these patches could not be distinguished from psoriasis palmaris, but on the fingers they were more like eczema.

On the sides of the fingers there were numerous little

minute vesicles, which tended rather to dry up than to break, and resembled the sago grains of cheiro-pompholyx.

Her history was that she had been liable to the eruption for thirty years. The first attack was at the age of 20, two years after her marriage, and she had had numerous attacks at irregular intervals since. She had attended twice before at the hospital, the last time four years ago. She had not observed any connection of the attacks with lactation. She had had a family of fourteen children, of whom nine were living. The attacks did not appear to have been connected with any special time of year. She complained that when the eruption was coming out she was usually very low-spirited. When the attacks were slight they usually got well spontaneously, but on several occasions they had lasted for two or three months, and required treatment. Her current attack was one of the severest she had ever had. It had never occurred on her feet, and had never passed higher than her wrists. She lived at Hackney. I advised a long course of arsenic.

CASE VII.—*Vesicating Erythema* ("Erysipelas")—*Many attacks during several years—Face, feet, and upper extremities affected.*

A stout, very florid woman, aged 35, attended at Blackfriars in 1875 on account of an eruption of small bullæ on the right foot, leaving small ulcers in a group on its inner side. Her statement was that she had been liable to the eruption on her feet on and off for four years. Usually it would get well after a short time, but it has now persisted for three months or more. Sometimes it had affected both feet at once, but usually only one. She had also often had similar spots (vesications, which would fester and become crusted) on her arms, and she now showed us some small scabs in front of each elbow.

The point in her case which chiefly excited my interest was her statement that she had for eight years been liable to attacks of "erysipelas on the face." Her description of these attacks was that they usually began by itching in the upper lip and burning in the cheeks; that next a few pimples would appear, and then watery bladders, "just as if I had been scalded," which would run a good deal. After a few days the attack would subside, and in the course of a fortnight she would be quite well again. Six or seven such attacks usually happened in each year. Her first attack had occurred eight years ago, during very cold weather, and apparently from washing her face in cold water after unusual exertion. The next morning her face was scarlet, and "little bladders" formed.

She was naturally florid, and was very liable to flush after meals. She had symmetrical patches of lichen-eczema on each side of her neck. A definite feature in the eruption had been its tendency to spontaneous recovery. The trunk had never been affected, nor the thighs or legs. She had never been able to connect the attacks with changes of weather or errors in diet.

CASE VIII.—*Recurring Cheiro-Pompholyx, possibly of catarrhal origin—Patient a married woman, in whose family some peculiar forms of Eczema had prevailed.*

The following case may serve as a good example of the difficulty or impossibility of making a diagnosis between acutely inflamed eczema of the hands and cheiro-pompholyx of neurotic origin. It is unquestionably an instance of an eruption which tended to spontaneous recovery and was liable to recurrence after an interval, and in this it differed definitely from common eczema. It showed also a very marked tendency to the production of "sago grains" deeply placed in the skin. On the other hand, many of its vesications were very small, like those of eczema; it never developed the large bullæ of cheiro-pompholyx, and although it got quite well, it did not do so quickly. I am inclined, however, definitely to separate it from common eczema, and to believe that it was not of local origin, but depended upon a nerve cause.

Mrs. C—— was a young married lady, æt. 26, of dark complexion, and, as she averred, in excellent health. She would not admit that she was nervous, or that she had ever suffered from any depression of spirits. She consulted me on February 20, 1885, with her left hand much inflamed. It was, she said, her third bad attack, but she had often been slightly threatened. The eruption always restricted itself to her hands; she thought that over-fatigue had some influence in producing it. The first attack occurred soon after her first confinement. The left hand was almost always the worst. The eruption usually began by crops of little vesicles between the fingers, which soon coalesced, when the whole surface became vesicated. From the fingers it would extend to the hands, but it had seldom passed much above the wrist. When Mrs. C—— came to me the fingers were all sore and peeling, as if they had been scalded, and crops of vesications just like those of slight scalds extended from the fingers to the hands. Many of the vesications had exceedingly delicate layers of epidermis over them. There were no large bullæ, nor any definite "sago grains." The other hand was scarcely affected, there

being only a few little vesicles between the fingers. The eruption had been coming out for ten days, and Mrs. C—— could assign no local cause. I prescribed a saline, and directed that the fingers should be carefully wrapped in a lead and spirit lotion.

On February 26, a week later, the fingers were very much better. There had developed, however, on both hands and wrists, a number of isolated large "sago grains." These were deeply placed, and occurred chiefly in the palmar surfaces. Mrs. C—— thought that they had been caused by the irritation of the applications; but this was scarcely likely, for they were abundant in the right hand, to which no lotion had been applied.

The following note was made a week later:—Mrs. C——'s case has assumed a fresh phase, the eruption being no longer confined to the hands. When I last saw her there were a few spots on the face, but they were of doubtful nature. To-day there is a copious eruption all around the lips and mouth and on adjacent parts of cheek. These are chiefly erythematous spots and patches, and none are distinctly vesicular, but some are acuminated like abortive pustules, or even a little resemble the sago grain. At the same time fresh crops have come on the hands, even on parts which had seemed to be getting well, and the eruption has spread higher up the wrists.

It should be stated that I had formerly treated Mrs. C——'s sister, Miss B——, for "eczema." I looked up my notes and found some important facts as to family history. Miss B—— was under my care in the latter part of 1874. She had been the subject of eczema from infancy. It had affected the popliteal spaces, elbows, fingers, and wrists, and was now mainly a dry intertrigo. Her father was said to have had the same from infancy till eighteen, when it left him. Most of her brothers and sisters had suffered from eczema in infancy, on the scalp chiefly. Miss B—— told me that her eruption was always worse in cold weather. Latterly it had been most severe in her hands, the thumbs and fore-fingers especially. Her nails had become rough. Under treatment she got quite well, excepting some little spots on the thumbs. She was obliged to wear wash-leather gloves in the house in cold weather to prevent relapses.

*(To be concluded.)*

## A PECULIAR FORM OF PARALYTIC DEMENTIA IN CONNECTION WITH INHERITED SYPHILIS.

On page 401 of my work on "Syphilis," there is a commentary with the title, "On the comparative rarity of diseases of the nervous system in inherited syphilis," and I had on several occasions previously asked attention to the fact, that as compared with the acquired disease, we but seldom see disorders of brain or spinal cord in those in whom the taint is congenital. I had from the first admitted that a few such cases do occur; indeed, I had myself published several. More recent experience has not led to any material modification of my first opinions. Although there has been a considerable increase of the facts at our disposal, and although many observers have recorded cases, yet the results obtained even by those who were inclined to think that I had understated them, have not led me to feel that I had erred much. After all it is only a question of degree. Undoubtedly the subjects of inherited taint are liable to all the disorders, whether due to inflammation, degeneration, or arterial obstruction, which may occur to those who have themselves acquired the disease. The zealous search of many enjoying excellent opportunities has, however, failed to show that paralysis, idiocy, dementia, and epilepsy are other than very rare in association with inherited taint. It was in the year 1858 that I visited the Earlswood Asylum for Idiots, in company with Dr. Hack Tuke, with the object of ascertaining whether any large number of the inmates showed signs of taint. Since then, Dr. Hughlings Jackson, Dr. Fletcher Beech, Dr. Judson Bury, and Dr. Shuttleworth have all made very valuable contributions to our knowledge of the subject.

I have to record to-day two cases which support the view

that there is a form of paralytic dementia which sometimes sets in from the age of three to six years, and is rather rapidly aggressive. Under it, a child of average intellect up to the age mentioned, and wholly free from paralysis, may be, in the course of two years, reduced to a condition of the most helpless idiocy. The symptoms suggest that it is an affection of the cortex, and very possibly of the pia, and that the changes are of a degenerative nature. Not improbably some transitory stage of congestion precedes the degeneration, but there are none of the more severe head symptoms, pain, convulsions, &c., which usually attend the presence of gummata. As we know that there is a form of aggressive choroido-retinitis, peculiar to inherited syphilis, which closely simulates retinitis pigmentosa, it seems not unreasonable to suspect that similar changes may occur insidiously in the grey substance of the cortex. This, however, is only hypothesis for the present.

*CASE I.—Congenital Syphilis—No infantile symptoms—Good health till the age of four—Aggressive General Dementia—Choroido-retinal degeneration simulating Retinitis Pigmentosa.*

The subject of the following case is a tall child, aged eight years, emaciated, and of pale, leaden aspect. She sits on her nurse's knee with her spine bent and "in a heap." Her head is usually turned to her right shoulder, and she constantly rotates it. Her mouth is always open, and she often lolls her tongue out, like an idiot. She frequently utters a sort of exclamation. She appears to take no notice of anything, but if for a few moments her eyes become fixed on anything the rotation of her head ceases. Up to four years of age she was quite well. She could then walk well and talk freely. A photograph is brought to me, which shows her a healthy-looking child without anything in physiognomy indicative of syphilis. Her ailments came on gradually. It was first noticed that her left ankle seemed weak and would bend over. After this both legs got weak, and she would easily fall. At the end of a year from this time she had ceased to attempt to save herself with her hands, and would fall on her face. Her speech began to become indistinct, and was gradually lost. At present she

never says more than "mamma," and one or two other short words.

There is not the slightest disorder of nutrition in any part. She never attempts to feed herself or help herself in any way. She sleeps well, and much in the day. She has no playthings, and takes no notice of anything.

She does not easily cry, and appears to be quite good-tempered. She did not resent the striking of her knees or the putting of drops into her eyes.

It is thought that she can distinguish her mother from her grandmother, but with one single exception a year ago, when she suddenly said "papa," her father thinks that she has not recognised him for three years past.

Any sudden noise throws all her limbs into spasmodic movement. Her limbs are exceedingly thin, and none of the muscular masses show up. Her elbows are always bent, and the fingers usually flexed strongly into the palms over the bent thumbs. They can, however, easily be straightened, and in sleep I am assured that the limbs are always quite limp and straight. Her feet are in a condition of talipes equinus, with some varus in the right one. The knees are bent and the flexor tendons tight. If she likes to resist, it takes much force to straighten her knees. The tendo Achillis is tight. Her extremities are very prone to become cold, even in hot weather. The knee-jump is at least normal. Her pupils are of equal size and small. She often turns the eyeballs upwards, but they do not oscillate, and she has no squint.

She can cry and shed tears, but does not do so freely. Her bowels are very costive, and she will often pass a week without any action. She often wets her bed, whereas before the beginning of her symptoms she was remarkably cleanly. Sensation appears to be normal, and she certainly felt tickling of her feet.

The ophthalmoscopic examination was difficult, as the head had to be forcibly fixed to prevent constant rotation. The pupils, small at first, had dilated well with atropine. The media were quite clear. In both eyes there was a broad peripheral zone of choroido-retinal disease, denoted by closely-placed roundish but not abruptly defined pigment accumula-

tions. The retinal vessels were so small that they could with difficulty be found. In the left eye I could not find them even on the disc itself. Of the discs I obtained only momentary glimpses. They were homogenous, hazy, and of a pale pinkish cream tint. Their margins were well defined, but there was an approach to the condition sometimes described as waxy.

It was impossible to estimate the child's vision or her hearing. My impression was that both faculties were very dull indeed. The eyes were but very rarely fixed on anything, and she never took notice of special objects. Any sudden noise made her start, but it was necessary that it should be very loud.

It is to be noted that although her muscles were so small in bulk they were very strong. When she chose to resist, it required much force to straighten her limbs or to fix her head. Her father had to use his strength to keep her head still during the ophthalmoscopic examination. She very rarely shut her eyes, and during my long attempt with the ophthalmoscope I had no difficulty whatever on that score. She kept her eyes constantly wide open. It would seem that her pupillary reflexes were normal, and the iris in full activity, for the pupils were small, and they dilated rapidly and fully under atropine.

As regards the diagnosis of inherited syphilis, there was nothing conclusive in her physiognomy or teeth. The latter were a little suspicious, however, and there were bosses in the frontal eminences. She was very small when born, but had no special illnesses in infancy.

Mr. J——, the father of the child, who came with her, gave me the following conclusive facts as to the syphilitic history. Nearly two years before the birth of the child he contracted, by an accident, a specific sore. Having no suspicion as to its nature, he unfortunately infected his wife, who had both a local sore and an abundant eruption. She required a long treatment, and even at the present time has some skin disease remaining (lupoid?). The husband himself never had any secondary symptoms, but had throughout good health, and at the present time appears to be very robust.



Although the dates cannot be fixed with exactness, it is probable that this child was born within a year or two of the syphilis in both her parents. It may be mentioned that during infancy the patient was treated with mercury.

The following is a statement of Mrs. J——'s pregnancies:—

1. The patient. The only one living.
2. Premature.
3. Premature.
4. Born dead.
5. Born dead.
6. Born dead.

Had it not been for the father's statement, I should have felt some doubt as to the existence of inherited taint. There can, however, be no doubt that the child is tainted, when we remember that both parents had suffered not long before her birth. There would appear to have been entire immunity from symptoms up to the age of four, and then a setting in with unusual severity of those atrophic changes which accompany the choroido-retinitis which simulates retinitis pigmentosa, and which produce conditions approaching idiocy. It is probable that the retinal changes represent others, much more extensive, in the grey matter of the brain itself.

CASE II.—*Congenital Syphilis—Fair health, but defective development of mental powers—At the age of six aggressive Idiocy—Raynaud's phenomena.*

The following case may very suitably accompany the preceding. It is an example of exactly the same form of disease, but has not as yet reached the same development. We have a child born of syphilitic parents suffering mildly from the usual symptoms in infancy, but afterwards, although of distinctly delayed development, enjoying fairly good health until the age of six. From six onwards to the present date (four years) there has been aggressive disease probably affecting the cortical substance of the brain, and producing general paralysis and idiocy. With this a most remarkable enfeeblement of circulation has been produced, attended with Raynaud's phenomena in a severe form.

Dr. G——, who sent the patient to me, wrote that he

knew that the parents and their children had suffered from syphilis. The following are the notes which I took.

R. J. L., æt. 10. Parents marriage fourteen years ago. Both parents suffered soon afterwards from syphilis.

1st, M. Dead, born at seven months.

2nd, F. Died at birth.

3rd, F. Lived to nine. Had affection of spine. Died.

4th, M. 10. The patient. A beautiful baby till five weeks old. Thrush badly. Convulsions at eleven months. No eruption remembered.

5th, F. Died from meningitis, aged nearly two years. One side paralysed. Symptoms of five months' duration only, and believed to have been caused by exposure to the sun.

6th, F. 7. Living, and healthy and intelligent.

7th, F. 4. Living, healthy.

8th, M. 3. Living, healthy. Had convulsions with dentition.

The mother's expression was: "All my children have had thrush, and badly. The thrush came out on the lower part of the body, and the mouth was sore."

Our patient could not walk until two years old. After that could walk and run well up to the age of six. Next it was noticed that his circulation was very feeble. One winter "an ear was caught," and a portion of it sloughed. His hands and feet would become blue, and "black knots" would form on the hands. No sores occurred. He never had anything called chilblains. His youngest sister has also suffered from cold hands. Their mother is a chilly subject. Her fingers in cold weather are apt to become numb. She never has chilblains.

It is about two years since he began "to fall about." He has now lost power in both hands and legs. He can only manage to stand, holding by the table. Last summer he could just walk alone; now he cannot walk at all. He has suffered from constipation all his life. It has been extreme. He never had power in his hands to write. He used to attend a Kindergarten, and liked it, but they found that he could not make strokes in letters. He never quite learned to read. He could talk well formerly, and repeat poetry, though always "childish for his age." Now he cannot speak so as to be understood by a stranger. He is unwilling to speak at all,

and never voluntarily moves himself. He sits with playthings in his hands, but does not play with them. His mother has to turn him over in bed, or he would always lay as at first put. He is rather stout and flabby. At home he is usually sallow and with sunken eyes; but when excited, or opposed, his cheeks become brick-red or dusky. They were very red when I saw him. Recently ulcerations have formed between his toes. He never perspires, and when his feet are livid they are very dry.

He sleeps fairly well. The paroxysms of coldness of hands and feet occur every day, and often several times in the day. His nails and fingers go quite black. The lividity extends half way up the calf. Sometimes the condition lasts most of the day. Usually it begins about three in the afternoon, and lasts till he gets to sleep.

We have here a well marked example of Raynaud's phenomena, and it is to be noted that they have been developed in association with advancing cerebral disease. It must be remembered, however, that the tendency was probably inherited, for both mother and a sister have shown it in slighter degree.

Dr. Shuttleworth, writing from his experience at the Royal Albert Idiot Asylum, has drawn attention to the fact that in some of the cases in which congenital syphilis is the cause, the children were healthy and intelligent during the first few years of life. His cases would some of them, indeed, appear to have been closely parallel to the two which I have here recorded. It is quite in keeping with what we know of some other phenomena of inherited taint that the occurrence of the symptoms should be delayed. The keratitis and the deafness, which are not uncommon, both of them usually set in at an age approaching adolescence. The same statement is especially true of the cases of aggressive choroido-retinitis with pigmentation, which are probably still more closely related to our subject.

## ON A CASE OF FATAL HÆMATEMESIS.

I WAS consulted about ten years ago by a middle-aged member of our own profession on account of extensive tertiary ulceration on his foot and leg. He had suffered from syphilis twenty years previously. He looked extremely ill, and as if not likely to live many weeks. He was very pale, and had been liable to vomiting of blood. His liver was not much enlarged, but could be distinctly felt to be hard and nodular. He did not take nearly so serious a view of his case as I did, being of a very cheerful temperament, and alleging that he had often been very ill before. He was at the time quite confined to his bed. I prescribed for him the three iodides, in a mixture, with a calomel pill; and under their influence he made the most astonishingly rapid and complete recovery. Within a few months he was again engaged in a laborious country practice. He remained under my observation at intervals of six or twelve months for the next eight years. During this time he never had any recurrence of his syphilitic ulcerations; but he suffered repeatedly from attacks of the most profuse vomiting of blood. These attacks occurred over and over again, and in more than one it was feared that he would die. I have never seen any one survive who presented a condition of bloodlessness equal to that which he showed on several occasions. His attacks of blood-vomiting would come on quite suddenly when he was not feeling ill. He assured me that the blood would pour forth from his mouth so that a large basin would be filled in the course of a quarter of an hour. On several occasions it had been necessary to leave him on the floor for the night, for fear that any movement might be fatal. Usually these attacks were over in the course of half an hour; but on more than one occasion they recurred during several days. As he lived in the country, I never

myself saw him during an attack of bleeding. The medical men who were called in to him always diagnosed ulcer of the stomach, and there seemed no other explanation of such profuse bleeding. Against that suggestion, however, there were the facts of long-continued liability, and an entire absence of stomach symptoms. There had never been any pain in the stomach, and as soon as ever the attacks were over Dr. I—— would begin to eat meat freely and to take port-wine in order to make up the blood he had lost.

The rapidity with which Dr. I—— recovered was most remarkable. He was an exceedingly plucky man, and a fortnight after an attack which had brought him to death's door, and made him look like the corpse of one who had been bled to death, he would be going about as usual and visiting his patients. In addition to the attacks of hæmatemesis he suffered also repeatedly from ascites. His abdomen would become distended until he could only just manage to walk about. Calomel was the remedy for this state of things. The ascites and the vomiting of blood generally occurred together; and the calomel, when given in conjunction with tincture of iron, so far from increasing his anæmia, seemed to help the process of blood-making. On one occasion, after a very severe attack, I had sent him to Brighton to recruit, and there his ascites became so distressing that he wrote to ask me to come and tap him. The next day, however, he was better, and within a fortnight, his gums having in the interval been a little sore, the fluid had almost wholly disappeared.

At length the end came. He had been attending to his patients as usual, and thought himself in better health. After having complained to his wife of a sense of weight at his stomach, vomiting of blood set in, and was so profuse that death resulted. I did not hear of the event until a week afterwards, and unfortunately no autopsy had been performed.

I have found in an old volume of the Dublin Hospital Reports a case which seems to supply what my narrative wants—post-mortem proof that this form of hæmorrhage may prove fatal, although no ulcer of the stomach be present. A man of 24, a tailor, was admitted under Dr. Cheyne's

care in an exsanguined condition from hæmatemesis. He had been ill only four days. He looked like a spirit-drinker, but he denied that such was the case, and said that a year previously he had suffered from a similar attack, and had almost died from it. In the interval and formerly he had had good health. During the three weeks that he was under Dr. Cheyne's care in the hospital ascites developed itself. Further vomitings of blood took place to the extent, on one occasion, of "four large basinfuls," and the stools also contained the remains of blood. After one of these attacks death took place. The post-mortem revealed a bloodless condition of all viscera, and mottled kidneys; but there was no ulcer in the stomach. The left lobe of the liver was enlarged and indurated.\*

During my poor friend's life we often discussed the question as to the source of the hæmorrhage, and were much puzzled to give any plausible explanation. That he was the subject of cirrhotic liver was undoubted; but the attacks were more sudden, more profuse, and more easily recovered from, than any which I have ever supposed to be explained merely by hepatic impediment. Since his death it has occurred to me as not at all improbable that he was the subject of varicosities of the lower œsophageal veins. For the reasons already given, it seems improbable that he had an ulcer of the stomach, yet the bleeding far more nearly resembled that of an open artery or vein than anything that we can suppose possible from mere congestion. The fact that the veins of the lower part of the œsophagus do become varicose, and are sometimes the source of fatal hæmorrhage, has been established by clinical observations which have been placed on record. I possess a French thesis by M. Eichhorst, recently published, which gives a detailed account of their anatomy and a summary of the cases previously recorded. The anatomical arrangement of these veins is such that they tend to dilate, as collateral channels, whenever the circulation through the portal vein or liver is obstructed.

An excellent paper on this subject was read at the Bir-

\* A Case of Melæna, with Observations, &c., by J. Cheyne, M.D. Dublin Hospital Reports, vol. i., 1818.

mingham meeting of the British Medical Association in 1890, by Dr. Stacey Wilson and Dr. J. R. Radcliffe.\* The first case published in Britain appears to have been one by Dr. Bristowe, in the Pathological Transactions. In this case it was specially noted that the liver was healthy, although the patient, a woman of 48, had suffered from ascites. She had died in her first attack of hæmatemesis. The vein which had bled was recognised at the autopsy. In the paper to which I have referred Dr. Radcliffe records five cases, several of which are very complete. He concludes his paper by expressing the belief that, if pathologists would look for these ulcerated œsophageal varices, they would be found much more commonly than is supposed, and that the theory of "capillary oozing as a cause of hæmatemesis would gradually ooze away." In one of Dr. Radcliffe's cases it is stated that the blood rushed from the mouth of the patient "as from a hose-pipe." He brought up on one day eighty-four ounces, on the next forty-eight, and on the day following forty.

A paper was read at one of our Medical Societies some years ago by Dr. Donald Hood on "The Hæmatemesis of Early Life." One of its main objects was to discredit, by post-mortem facts, the too prevalent belief that profuse and fatal bleeding from the stomach necessarily implies the existence of an ulcer.

As an illustration of the profuseness with which bleeding may occur from a ruptured varix, the case of a distinguished London physician may be mentioned, who, some years ago, died in his own house, before assistance could be procured, from the giving way of a vein on the surface of the abdomen.

\* The patient whose case I have recorded above died before either this paper or the Paris Thesis were published, and I had not therefore the advantage of being acquainted with their contents.

## MUSEUM NOTES.

(Continued from page 189.)

### *A Duplicated Limb with arrest of growth.*

A specimen in the Dupuytren Museum, No. 148, is the skeleton of a cock which had been allowed to attain full age and has a strong spur. It has, however, only one, and during life may have ranked as either one-legged or three-legged. It has but one well-formed and complete leg. It is its left. On the right side two large femora articulate side by side with the pelvis, but both end in irregular developments of bones, which have no feet. It is probably an instance of duplication of a member by dichotomy with subsequent arrest of growth. It is described as "Un coq, monstreux; Genre, Ischiomèles." Dr. Duplay.

### *Deficiency of Ulnar Digits with dwarfing of carpal end of Ulna.*

Deficiency of the ulnar digits (a very rare defect) is illustrated by specimen No. 32 (Teratologie) in the Dupuytren Museum. A cast and a skeleton of hand show the little and ring fingers with their metacarpal bones wholly wanting. The bones of the carpus appear to be anchylosed and to consist of two only, or rather three, for the pisiform is quite definite and large. The ulna is well formed at the elbow but is too short and somewhat defective at its carpal end. This has led to much bending of the radius. The three digits which remain are rather long and large, the middle one especially so.

### *Examples of Arrest of Development of the Spinal Column.*

There are cases of arrest of development of the spinal bones which may possibly be the converse of those in which



the limbs are defective. At any rate, it is clear that the laminae of the spine may be absent in its whole length, and even the cranium absent also, whilst the limbs are well developed. In these cases the spine is usually very short, and, it may be, placed almost horizontally.

In the Dupuytren Museum 90a is an example of a foetus of the kind described. The head is of fair size, but the trunk is so short and so almost horizontal that the hands touch the feet. 90 shows an approach to the same condition.

85, 86, 87, 88, and 89 show similar states, but in all the head is also very defective.

90b is also a short-trunked dwarf with good limbs.

#### *One-sided Arrest of Development of Lambs.*

M. Philipeaux has placed in the museum (it has no number) the skeleton of a hydrocephalic foetus, which at first sight appears to have only one leg and one os innominatum. On more careful looking, however, a malformed limb with displaced os innominatum is seen curled up on the back. There is a femur and a tibia, much altered in shape, no fibula, no tarsus, and only a single digit. The upper extremities are well formed, but the left is rather the larger, and all the left ribs are much longer than those of the other side, thus displacing the thorax to one side in a manner which I never saw in any other specimen.

It is an example of one-sided defect of development, the defect being slight in the upper limb and trunk but great in lower limb.

#### *Symmetrical Depressions in the Parietal Bones (the so-called Senile Atrophy of the Skull).*

In the Dupuytren Museum there are five calvaria which show this peculiar condition, and which are nearly all alike. They are 439, 431A, 439B, 438, and 441. They are described "Atrophie Senile et symétrique de la partie eurilleuse des parietaux."

Three of them show a central furrow passing downwards and backwards between high ridges of dense bone. These ridges separate the furrow from the lateral pits: 439 shows

this in a very marked manner, and it also has several other smaller round pits behind the principal ones.

Skull-caps showing these peculiar depressions are very rare. I have seen them in but few museums. Our own College of Surgeons collection possesses three or more. One of them is from Egypt, given, I believe, by Prof. Flinders Petrie. They are much like those in Paris. These depressions are not like those produced by disease, and they are always symmetrical. It occurs to me, in default of a better explanation, that they are due to wearing some specially adapted form of saddle for the head upon which burdens were rested. The Egyptians were, it is known, much in the habit of carrying on the head, and so are the Parisians of certain callings. The English, Germans, and Scandinavians use the head but little for this purpose. If it be objected to this suggestion that, were it correct, these skulls ought to be much more common than they are, I reply that only a minority of clergymen show well developed "pray-patches," and that although many French street-barrow-men yoke themselves to their trucks, "Psoriasis en bretelles" is yet very uncommon.

Mr. Eve has described the College of Surgeons specimens in the Pathological Society's Transactions, vol. 41, p. 244. Four of those in the Dupuytren Museum to which I have above referred were long ago alluded to by Sir George Humphry in his work on the Skeleton. Dr. Maier has described two which are in the Freiburg Museum. All admit that they are the skulls of old persons, mostly of old women. One of the three in our own College of Surgeons Museum is that of a Wallachian gipsy woman from the Barnard Davis collection. The vocation of the subject in this instance may perhaps give some support to my conjecture as to their cause. It may add to its plausibility if we reflect that it is probably when the habit is continued into old age that it produces atrophy.

I have obtained for my museum some excellent photographs of the Paris skulls.\* I find it very difficult, in spite of Mr.

\* I have the negatives, and can supply copies.

Eve's ingenious explanation, to believe that the depressions are of spontaneous origin.

*The Encrusting Periostitis of the Lower Animals.*

I have several times in my ARCHIVES referred to the subject of "Encrusting Periostitis" as it is seen in the skeletons of certain mammalia. Almost all our large country museums contain one or more specimens of it. A few weeks ago I had half an hour in the museum at York, and there noticed the skeleton of a young but full-grown lion which afforded a good example. Almost all the long bones were roughened over by a thin deposit of new bone. The condition is wholly distinct both from rickets on the one hand and osteitis deformans on the other. It consists in the formation over very large areas, or perhaps over almost the whole length of a bone, of a thin deposit of new bone, hard in texture and rough, so as to form small stalactites. In the human subject it is closely simulated by bones which have been inflamed after compound fracture, and sometimes, though less accurately, by syphilis.

The best specimen that I know of is that of an old dog in the museum of the Edinburgh University; but the skeleton of a tiger which stands at the head of the staircase in that of Trinity College, Dublin, affords also an excellent example. Others more or less good I have found in almost every museum that I have recently visited. It would appear probable that the condition is more common in animals which have been domesticated or kept in confinement. Sir William Turner showed me in Edinburgh the vertebra of a whale which suggested similar changes. Unfortunately none of the long bones of this animal were forthcoming.

Mr. Platnauer, the able curator of the York Museum, was good enough to examine the skeleton above referred to more carefully after I had left. He informs me that the bones on both sides are attacked symmetrically, and that the ischium, ilium, and pubes, femur, tibia, fibula, calcaneum, tarsals, and metatarsals are all extensively affected. The humerus, radius, and ulna have also suffered, but less severely than the bones of the lower extremities. The rami of the lower jaw are also slightly attacked on their inner sides.

Nothing is known as to the history of the animal during life. The skeleton is one of many given to the museum by the late Mr. James Atkinson, the learned and witty author of "Medical Bibliography" (1834), and formerly a vice-president of the Yorkshire Philosophical Society and surgeon to the county hospital. It is probably that of a menagerie animal, and its epiphyses denote youth.

The following notes were made on the occasion of a recent short visit to the Pathological Museum of the Leeds Medical College :—

*Specimen showing transparency of Gangrenous tissues.*

Amongst the specimens in the Leeds Museum there is one showing a condition of transparency of the skin and soft structures of the foot, such as I never saw anything at all equal to. You see through the skin of the digits as if looking through yellow glass, and the forms of the bones can be distinctly traced. Cellular tissue, ligaments, and everything have become quite transparent. The skin is not contracted on the bones ; it is, on the contrary, swollen and tight, as if from œdema. The specimen is mounted in turpentine, and I should have supposed that the peculiar transparency had been produced by that medium, had not Mr. Haigh, the curator, assured me that the condition was almost as marked during the life of the patient, and that the specimen had been preserved on account of that peculiarity. The foot was that of a woman, aged about 47, who had died after gangrene of both legs, in consequence of plugging of both external iliacs. The limbs had become, I was told, almost black about the knees ; but one of the feet, instead of mummifying, had become somewhat swollen, and passed into this peculiar transparent condition. The transparency was greatest on the backs of the digits, but affected more or less the whole of the foot. The nails were opaque.

The gangrene did not occur quite simultaneously in the two limbs. One had been amputated (by Mr. Mayo Robson) a month before the other became gangrenous. It was the second only which assumed the peculiar transparent condition. The notes of the case on the day before the patient's

death describe the foot as "dry, hard, and somewhat swollen." The transparency was such that "the joints of toes, phalanges, tendons, and subcutaneous vessels were clearly seen."

*Plugging of Aorta with Gangrene of Limbs.*

No. 150 in the Leeds Museum is a splendid specimen of plugging by fibrinous clot of the abdominal aorta at its bifurcation and of both common iliac arteries, the patient having died of gangrene of the legs.

*Peculiar condition of Skin in foetal Pigs.*

I was interested in observing the state of the skin in two foetal pigs, which had been preserved on account of malformation of the head—in each case, I think, the cyclops condition. The skin of the back and sides of the animals was, in each instance, pitted over with shallow depressions of various sizes, and none larger than a split pea, most of them much less. The rest of the skin was plump and smooth. It is often observed that animals, which are malformed in one structure, exhibit at the same time defects in others which are apparently quite unconnected. The little cicatricial pits were arranged symmetrically on the two halves of the body, and the animals, so far as my cursory examination went, showed no other malformation.\*

*Hydrocephalus in a Calf.*

No. 215 is the skull of a calf showing congenital hydrocephalus. The cranial cavity is of enormous size, and the bones are thinned out in the most extraordinary manner. Unfortunately craniotomy was necessary in order to effect delivery, and thus the opportunity for dissecting the brain was lost. Although the condition is a rare one, it is not, I believe, so infrequent but what some zealous young surgeon, enjoying a certain amount of leisure in country practice, might, by making interest with the veterinary surgeon, procure a specimen for careful dissection.

\* Mr. Haigh has since been good enough to examine these pits carefully. He believes that they represent gland orifices and hair follicles, and result from maceration.

*Intra-uterine Amputations associated with defective formation of face.*

One of the foetuses, illustrating intra-uterine amputations, is of considerable interest, on account of the different stages of the amputation at the same time in different parts. The right thigh presents a well-healed stump, which has already by continued growth of bone assumed a conical form. Some of the digits, however, constricted at their bases, have not yet dropped off. Two of these, very short, and of which the growth has evidently been arrested, look as if just about to detach themselves; whilst another, of full length and well formed, shows at its base a deep furrow of constriction. The nose in this foetus presents the curious condition, which we sometimes see, of depression with an almost bifid condition, there being a deep vertical indentation in the lip and nose, as if a cord fastened to an incisor tooth had passed upwards to the forehead. This malformation of the nose is usually coincident with hare lip and cleft palate. I could not ascertain whether the palate was cleft in this instance, the specimen being in a bottle. There is no very obvious explanation of the association of cleft palate with intra-uterine amputation of limbs.

*Well-formed Limbs with arrest of development of Cerebro-spinal Centres.*

Three partially acephalous foetuses, with the head thrown back, and the upper part of the spinal canal open (as usual), illustrate the well-known fact that perfection in the development of the limbs is not dependent upon perfection of the cerebral and spinal centres. In all four the limbs were well formed. One of them was the subject of a large hernia; and the other showed the peculiarity of having its body covered with downy hair of very considerable length.

## A PECULIAR FORM OF HYPERTROPHIC ACRO-DERMATITIS IN ASSOCIATION WITH GOUT.

THE malady which I wish to describe in the present paper is by no means a simple or specific one. Yet it appears to be fairly well specialised, and clinical convenience will, I feel sure, be served by separating it from others. It has alliances—probably essential ones, and not of mere resemblance—with psoriasis, xanthoma, and chilblains, whilst the main cause of its peculiarities is, I think, an inheritance of tendencies to gout. It is not probably a direct phenomenon of active gout, but rather a result of those peculiarities of tissue-tendency which the descendants from several generations of gouty ancestors inherit. Thus it will be seen that the malady in question is one involving, as do many other curious and well-characterised chronic disorders, a very complex partnership of causes. From this it will follow that we ought, in connection with the different shares taken by the several partners in different cases, to expect considerable modifications in the final result. We presuppose peculiarities in the endowments of the skin itself tending to chilblains; of the vascular system, tending to venous congestion; of the liver, giving liability to xanthoma; of the kidneys and digestive functions, giving tendency to gout; of the wholly unknown peculiarity which conduces to psoriasis; and, perhaps I ought to add, in deference to the opinions of some who would claim the malady as “sarcoma,” of an inherited tendency to malignant new-growths. Out of such various pathogenetic forces it is obvious that there may be constructed a malady which, whilst in the main well characterised, may yet manifest considerable modifications in different instances. A plum-pudding, to use a

homely simile, may keep its name and its character, though the proportions of plums, sugar, eggs, &c., may vary in different examples. It is, I think, exactly so in the case before us. In some cases there is more of psoriasis and less of chilblain, in some more of gout and less of psoriasis, whilst in some the xanthelasma element may perhaps be wholly omitted.

The conditions to which I refer are amongst the rarities of dermatology. We encounter them at various ages. One group, which I will for the present call the "Judson-Bury Group,"\* occurs in early life, before any habits of the individual can have done much to strengthen the tendency to gout, and in these we must expect a very decided history of inheritance. In a second group the disease does not begin till past middle life, and occurs to those whose mode of life has conduced to gout. Between these, however, we have other cases in which probably both inheritance and acquisition of gout take their share, and which may begin at any period of life.

As the cases which I have published as examples of this malady are scattered in different works, it may be convenient if I give a brief *résumé* of them.

CASE I.—In January, 1869, I first saw John W——, then aged 58, whose case is given with a portrait in Vol. I. of "Clinical Illustrations of Surgery." His patches on his hands had been present two years. He lived ten years longer, and then died, of gouty kidneys, in King's College Hospital. During the whole of this time his disease had continued to advance, the patches increasing both in size and number. They were remarkable for their purple tint. They occurred symmetrically, and, I believe, to the last were on the extremities only. Throughout there was nothing to suggest malignant tendencies. The patches were thick, congested, and consisted chiefly of solid œdema. They were clearly infective in the same manner as psoriasis is so, and

\* Dr. Judson Bury, of Manchester, published in the *Illustrated Medical Journal*, 1889, the first good example of this form with which I am acquainted. He was good enough to supply to me some further particulars respecting this patient, which I published, together with a plate copied from his, in *ARCHIVES*, Vol. II. 300. This plate, for the convenience of my readers, I now again append.



they affected some of the regions often attacked by psoriasis. The man had suffered severely from gout during almost his whole life.

CASE II.—This I know only from a portrait, having never seen the patient, and no history was to be obtained. The portrait was shown me by the late Professor Boeck in the collection in the museum at Christiania. It represented the hand of a Swedish sailor. I can only say that it was exactly like the hand of my patient, and that I have no doubt whatever as to its being an example of the same malady.

CASE III.—Mr. B——, a florid farmer, aged 65. He had been for some years (five at least) the subject of symmetrical patches of a blue or livid colour, which were confined to his limbs. They occurred symmetrically, and affected some of the psoriasis positions, but were not restricted to them. Extensive induration of the cellular tissue had been produced in connection with the patches; there were many dilated venules, and, as a peculiar feature which I have not seen in other cases, must be noted little subcutaneous cords (veins or lymphatics) which ran up from the patches. Two injuries to the shin, one a severe wound, were supposed by the patient to have had some share in exciting the disease. He was a man very likely to have had gout, but I am sorry to find, on reading my record of the case (see *British Journal of Dermatology*, vol. i. p. 8), that I have omitted to record the evidence which I cannot doubt that I obtained.

I will leave aside several cases in which I have seen the early stages of this malady, but in which no development occurred under my observation which would justify a positive diagnosis. I suspect that gouty men not unfrequently show these patches for a time, and that the affection is by no means an incurable one in its early stages. As in so many other maladies which are accounted rare and very peculiar, it is probably only a minority which we recognise and name—those, to wit, of severe form, long duration, and with pronounced aggressive tendency.

I will now pass to the cases which occur in younger persons, and in which the *inheritance* of gout is to be suspected. These I will for the time venture to call

## THE JUDSON-BURY GROUP.

CASE IV.—Dr. Judson Bury's own case will be found in the *Illustrated Medical News* for May, 1889, and it is recapitulated with additions at p. 300, Vol. II. of my ARCHIVES (see portrait LXI.). Its subject was a girl twelve years old when the sketch was taken, and now seventeen.\* The parts affected, in addition to the hands and feet, were the psoriasis positions, and the disease showed accurate bilateral symmetry. It was slowly aggressive, and I believe is so up to the present date, but whilst some patches have increased, others have disappeared. The patient, a girl, is still in good health. She has herself had an illness which was called rheumatic fever, but it is not known that she inherits gout.

I will now relate two which have come under my own observation recently, and which constitute my reason for writing the present paper. They are very definite examples of the malady in question, and in both the history of family gout is very strong. It is also in connection with their history that I feel justified in introducing the element of feeble circulation and chilblains as an important ingredient in the causation of the phenomena. In the first of these the disease began not on the hands, but on the elbow tips.

CASE V.—Miss U——, now aged 20, was brought to me by Dr. ——. She had not suffered from any particular disease, excepting quinsy, until her present malady began about eighteen months ago. The first symptoms were patches on her elbows. Her hands soon after became affected with little indurations in the skin, and she had patches in the psoriasis positions on the fronts of the knees. A lump also formed on one heel. Thus far the elbows, hands, and one heel have been the only parts affected. She was one of twelve, all living. Two had suffered from infantile jaundice.

The family history was of strong inheritance of gout, and of tendency to torpid livers. Many members of the family had suffered from the latter. Her paternal grandfather had

\* The earliest example of the disease in the adult with which I am acquainted is that given in my "Illustrations of Surgery," p. 42, Plate VIII.

"died of gallstones," having previously suffered from jaundice.

*Present Condition* (Nov. 20, 1890). On the elbows and knees there are groups of ill-defined papules on a congested base. On one knee there is but little more than a patch of congestion, the tubercles being very ill-marked. On the heel there is only a patch of inflamed skin, such as might have been caused by chafing. It is just over the attachment of the tendo-achillis. The hands present conditions which are almost symmetrical; lumpy and nodular thickenings are seen under the skin of all the fingers. Some of these lumps are quite isolated, glossy and semi-transparent, but others are more deeply placed and less defined. The ring fingers of both hands have almost wholly escaped. The symmetry is not, however, exact, for in the left hand the middle, ring and little fingers have almost wholly escaped. In the right hand the little finger is severely affected. The right thumb, middle and index finger, and left index finger are those most affected, and in these the subcutaneous nodules are so numerous that they are almost confluent. None of the nails are in the least involved. In each hand a patch passing up from the base of the palm to the index finger is very conspicuous. In the left hand, on the ulnar border just above the wrist is a large thick induration which has no representative in the other. There is no yellow xanthelasma deposit in connection with any of the growths; excepting that this feature is absent, they resemble what is seen in tuberous xanthelasma. Miss U—— says that they frequently burn and smart. She has recently been advised to take port wine, and says that it distinctly makes the lumps worse. Miss U—— is a tall, well-grown girl, but pale and of somewhat feeble circulation. Her case is evidently a partnership of tendencies to gout and xanthelasma, with possibly a tendency to psoriasis also. The nodules are somewhat like those described as rheumatic nodules, but they become much more superficial and cutaneous, like those of xanthelasma. They are in the positions, in part at least, which are affected by psoriasis and also by xanthelasma. The severity with which her fingers have suffered must probably be attributed to her feeble circulation.



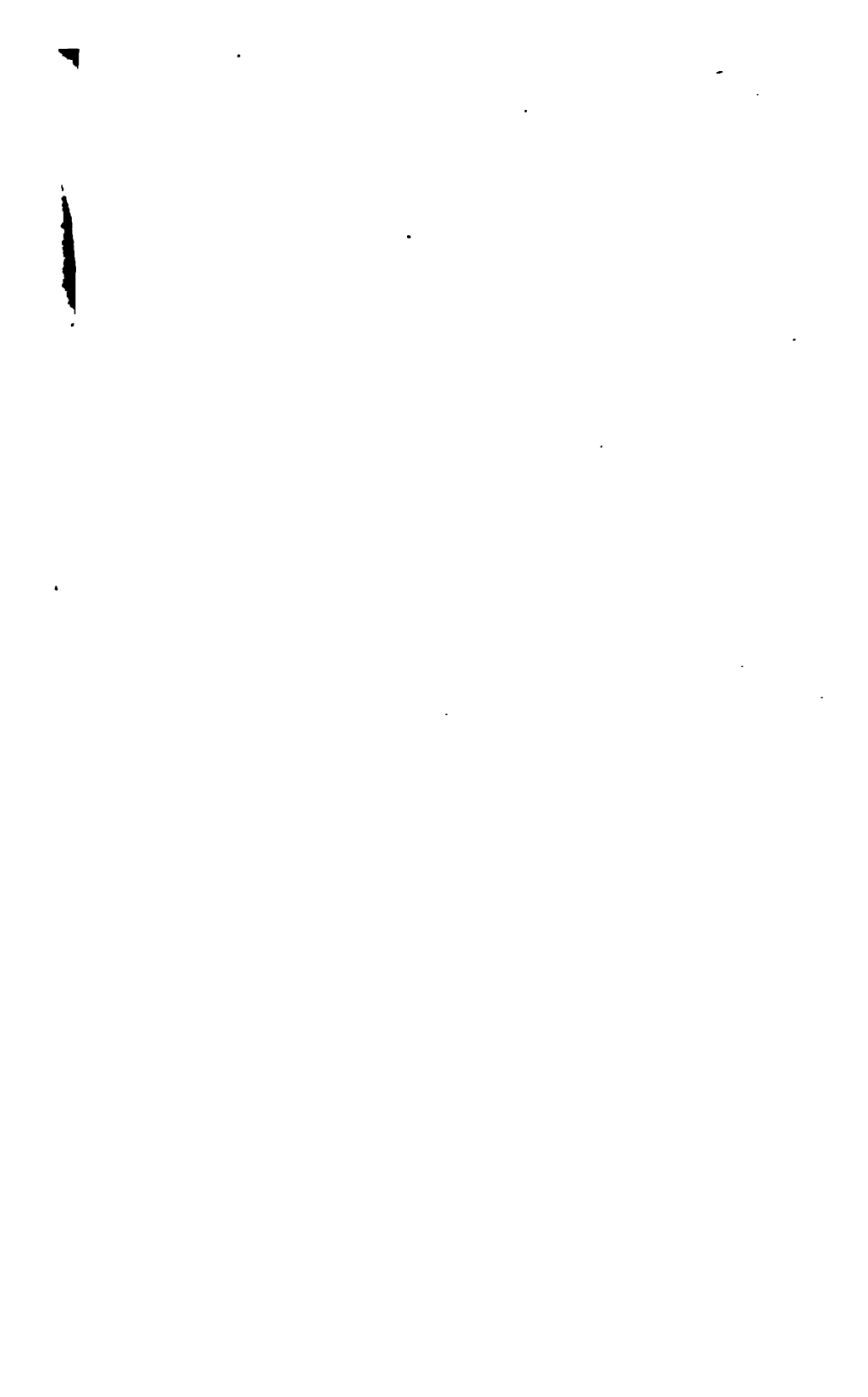
Fig. 1.



Fig. 2.

Remarkable disease of Hands.  
(Copied from Dr. Judson Bury.)

West, Newman, &



On January 18, 1894, this patient was good enough to attend one of my demonstrations at the Clinical Museum. During the three years which had elapsed her condition had undergone but little change.

CASE VI.—Mr. R——, a healthy man, aged 25, sent to me by Dr. White, of Nottingham, was the subject of a very peculiar eruption which affected the psoriasis positions, and in addition his ears and fingers. Yet it was nowhere like psoriasis, the patches consisting of aggregated little tubercles which desquamated but did not form scaly accumulations. On his ears, both helix and anti-helix, there were a number of conical whitish tubercles, deeply placed, and which might easily have been mistaken for tophi. They were, however, not tophi, but of fibroid structure. The whole ear was dusky and thin. His right hand was more severely affected than the left, but both hands showed many papules and nodules arranged more or less in groups. Some of these were very ill-defined, but others, having become confluent, had formed distinct rings. They were attended by a certain amount of infiltration of the subcutaneous tissue, and were of dusky colour. Most of them were smooth on their tops. They were very painful if struck, but not otherwise. He described their development by saying, “A little nodule forms first, which scales and then dies, and others form around it and thus make circles.” His face was quite exempt, but on both elbows and on both knees there were confluent groups of smooth tubercles. The patches appeared to be spreading at their edges, and those on the knees, although very near to them, were not exactly on the psoriasis positions. The history which he gave was that it was three years since the first patch appeared on his right hand. For some time before that he had been suffering from warts on the hands, to which he had been applying caustics. This eruption followed the warts, and, as he thought, had been caused by them. For about a year the spots on his hands made but little progress, but for two years past they had been almost in their present condition. He had been travelling in India and Australia, and during the whole of these two years had never been exposed to winter cold. He was a tall man, of clear, good complexion, and had never

suffered from syphilis. From his father he inherited a feeble circulation, and his maternal grandfather and great-grandfather had both suffered severely from gout. His mother was the subject of chronic rheumatism. He stated that he had been born in Nottingham, and that he had enjoyed good health as a boy, though liable to biliousness and always sleepy in hot weather. His skin did not appear to be especially affected by the sun. He stated that he browned well and never blistered. He thought that neither heat, cold, sun, nor wind had any influence on his eruption, but in cold weather his hands and ears easily became numb. The coloration of his cheeks was somewhat patchy. His pulse was of good power but slow—64. The patches were undoubtedly spreading serpiginously. Some of them showed a tendency to form large circles. No definite scar was left where the condition had subsided. The borders of the patches were made up of a number of crescents (aggressive). The peeling was more like that of lupus exfoliatus than of psoriasis.

CASE VII.—Of this case I have seen only a portrait. It was shown me by Dr. Radcliffe Crocker. I was at once struck by its close resemblance to Dr. Judson Bury's case. It was that of a young person, and Dr. Crocker subsequently told me that there was a clear history of gout.\*

I have yet several other cases to narrate which bear upon this subject, though not exact parallels to those which I have given. One of them shows the coincidence of xanthelasma, and justifies, perhaps, more than any of the above my plea for the admission of a tendency to it as being one in the partnership.

\* Since this was in type, Dr. Crocker has published his case, with a good portrait, in the *British Journal of Dermatology*.

## TWO FATAL CASES OF OBSTRUCTIVE JAUNDICE.

THE two cases which follow are of much interest as illustrating the symptoms which may attend obstructive jaundice from irremediable cause.

CASE I.—*Sudden onset of illness with Abdominal pain, Jaundice and Purpura—Jaundice persistent until death in the eighth week.*

I saw with Dr. Reynolds, of Stamford Hill, on Saturday, Jan. 7, 1898, a very interesting case of obstructive jaundice. The patient was a young man of twenty, standing at least six feet high, and habitually thin. He had some slightly enlarged glands in the neck and in the groins, but they had never given him any trouble, nor had he before his present illness regarded himself as especially delicate in any way. He had been about five weeks in bed with persistently high temperatures, increasingly deepened jaundice, bile and albumen in his urine, and entire absence of bile in his stools. His illness had commenced with what was supposed to be a catarrhal attack affecting his stomach and liver, and the jaundice did not set in until he had been a week in bed. About the end of a fortnight from the beginning of his illness he had been covered with purpura from head to foot, but without any hæmorrhage from mucous membranes. This purpura did not last long, and it had absolutely disappeared some time before I saw him.

I found Mr. R—— extremely emaciated, and presenting everywhere a deep yellow tint. The tint was slightly brown, but inclining to a lemon-yellow. His tongue was furred with a broad dry streak down the middle. His pulse was quickened and hard; it might, indeed, be described as wiry. I could trace



his radial artery in his emaciated arm with great ease nearly up to the bend of the elbow, and, on my noticing this, his mother remarked that his pulse could be felt anywhere, even by the sides of his fingers. This I found was quite true.

Mr. R—— had been seen in the beginning of his illness by Dr. Goodhart, and later on by Dr. Harley. It appeared tolerably clear that he was suffering from obstructive jaundice, and the question to be determined was as to the probable nature of the obstruction. In order to determine this, I questioned him closely as to the way in which his symptoms had developed. It appeared that he had been seized with pain suddenly one morning whilst walking in the street. The pain was such as to induce him, a few hours later, to leave business and go home. He rested on the sofa, took a little brandy, and then went to bed. On the following morning he was sufficiently recovered to eat his breakfast and go to his office; he returned, however, in the evening, again with pain, and had a bad night. The next day he was seen by Dr. Reynolds, and during the whole of the next week there was very considerable pain over the region of the liver. The pain had, however, at no time been of a very severe character, and was described as aching rather than spasmodic. At first there was nothing to be felt in the abdomen, but more recently the indurated border of the turgid liver had become perceptible. He had never had any "liver attack" before, nor was there any history of gall-stones in his family. One sister had had a slight attack of jaundice.

The abdomen when I saw Mr. R—— was rather swollen, and although tympanitic in front, possibly contained some fluid. I could not feel anything definite in connection with the gall-bladder. The whole region was somewhat tender, and he preferred to rest with his knees drawn up. It seemed to Dr. Reynolds and myself impossible to say whether the obstruction was due to a gall-stone, or to pressure from enlarged glands, or any inflammatory swelling external to the duct. We discussed carefully the question of operation, but finding the parents of the youth very averse to any suggestion of the kind, we did not feel justified in urging it upon them. We agreed that, on the whole, his chance of recovery

was quite as great without it. At the same time we were obliged to give a very doubtful prognosis. It will be seen that there were two or three objects which might possibly be served by operation. First, there might possibly be a gall-stone, which might be removed; secondly, although the cause of obstruction might be irremediable, it might be a gain to the patient to establish a biliary fistula, and thus save him from the poisonous effects of bile in his blood; thirdly, there might be some abscess, the opening of which would afford relief.

It is to be noted that the symptoms attending the commencement of the illness, although they seemed to point to plugging by a calculus, were by no means conclusive; for the pain, although it began very suddenly, had not been persistently severe. I did not see the patient again, but the following letter from Dr. Reynolds supplies the sequel:—

THE ELMS, 128, STAMFORD HILL, N.,

March 17, 1893.

DEAR MR. HUTCHINSON,—The very interesting case of jaundice you saw with me in the early days of January terminated on the 17th of that month, and the result of the post-mortem will be of especial satisfaction to you, as, if you remember, we thought it wise to discard all thoughts of exploration.

The cause of the obstruction was glandular carcinoma of the head of the pancreas, involving by pressure the bile duct and spreading to the mesenteric glands in the immediate neighbourhood. The microscopical appearance of the gland in the groin was of the same nature. The case lasted for exactly seven weeks—no complaint at all having been made previously, though to my certain knowledge the gland in the groin was there before. Evidently he had nothing to complain of until the growth began to press on and involve the bile duct, and then the distress came.

Believe me, yours faithfully,

W. PERCY REYNOLDS.

CASE II.—*Case of Prolonged Obstructive Jaundice—Cholecystotomy performed—Malignant Growth—Death.*

I visited Mrs. H—— at her house in Guildford in consultation with Mr. Parson, of Godalming. I had been told that she had been long ill with jaundice and sickness, and that

whilst malignant disease was strongly suspected, it was yet wished that the question of operative exploration should be fully discussed.

I found Mrs. H——, a lady of sixty-one, the subject of deep jaundice. Around her eyelids the tint was almost black, and on all other parts of an intense dark yellow. She had been confined to her bed for about fifteen weeks on account of loss of strength, attended with sickness and entire failure of appetite. Her more severe illness and the setting-in of definite jaundice dated from September, 1891; my visit to her was on January 10, 1892. I had been told that there was distinct fulness over the liver, such as had led to the suspicion of a cancerous growth. The abdominal examination was not very easy, for although she was emaciated and the abdominal wall very lax, it was yet loaded with fat and the muscles were remarkably resistant. It was certain, however, that there was an ill-defined swelling about the region of the gall-bladder, and it was only on pressure at this point that she made any complaint of pain. There was not the slightest ascites, nor had there ever been any symptoms indicating abdominal obstruction. The bowels, which had formerly been very costive, were now acting regularly, but the stools were quite white. The urine was loaded with bile.

Mrs. H——'s history was that she had been through life dyspeptic and bilious, and often very dark around the eyelids. No one had ever suggested that she was the subject of gall-stones, nor had she ever been jaundiced. Although her definite and severe illness had set in only in September, yet for six months before that she had been somewhat failing in health, and, as her daughters thought, had been looking yellow.

One point was perfectly clear in this case—the patient was suffering from some obstruction to the common bile-duct, her jaundice was intense, had been persistent for at least four months, and was increasing. There were several points in the history which appeared to me to point rather to plugging by a gall-stone than to the presence of a malignant growth. Although the patient had failed much in health during her illness, yet I was told that she was not now getting worse; that, in fact, the sickness was much less than it had formerly

been. Two months ago her death had been expected, but since then she had decidedly gained ground a little. The fulness which was present over the liver had remained much as it was from the first, no fresh tumours had formed, there was no evidence of disease in other parts of the abdominal cavity, and the quantity of bile excreted in the urine made it certain that a large part of the liver, at any rate, was still capable of functional activity. The symptoms had in fact been throughout those of biliary obstruction, and nothing more. I was therefore inclined to think that the probability was in favour of the absence of cancer, and that we ought at any rate to give her the chance which an exploration would afford.

A few days after my first visit I explored the gall bladder. It was of large size, being distended by thick bile. It did not contain any calculus. Having ascertained that there was a round hard growth as large as a marble which adhered to the common duct and occluded it, I contented myself with leaving a drainage tube in. The operation gave apparently some relief for a few days, but hæmatemeses subsequently occurred, and the patient sank about a week afterwards. There was no autopsy.

## SYPHILIS SIMULATED BY GOUT AND STRUMA.

A GROUP of cases are coming to our knowledge in which conditions occur most deceptively like those of syphilis, and of which the diagnosis is to the last degree perplexing. Thus we have been accustomed to regard multiple periostitis—the simultaneous production of node-like swellings on various bones—as almost conclusive evidence of specific taint. The cases which I have published, in which such swellings followed quickly after vaccination, have, however, much weakened this impression. To them are added certain others in which evidences of some kind of blood poisoning, with periostitis as a result, occurred without any proof of either exanthem or syphilis. We encounter, too, sometimes with nodes and sometimes without them, certain forms of sore throat most deceptively like syphilis, but in which neither the previous history nor the subsequent progress bear out such diagnosis. It must be admitted that to every one of the cases to which I now refer, some doubt as to the diagnosis was present to the last, and difference of opinion existed amongst those who were consulted. It is, indeed, in this very fact that the main interest of the cases to which I refer consists. Many observers enjoy a high degree of self-confidence in respect to the recognition of specific manifestations, and will pronounce that a given lesion is syphilitic on its appearances, and irrespective of the history and course. I have myself been puzzled sufficiently often to be no longer of the class referred to.

I have to-day to place on record in some detail a case of the kind referred to, in which during a long course of years various opinions had been expressed with great confidence as to whether or not the patient was syphilitic. My own belief

is that he inherited gout and struma, and that under their influence the lesions of syphilis were simulated, but I must speak with some hesitation. In order that my readers may be the better prepared to estimate the items of evidence in this remarkable case, I will briefly recapitulate the facts as regards some others which more or less closely resembled it.

Some years ago a lady of good family, and single, was brought to me by a throat specialist for "a syphilitic throat." Her tonsils and pharynx were covered with white-edged patches of the most suspicious aspect. The surgeon who brought the case would not admit a doubt, and he had already obtained a corroborative opinion from a specialist in syphilis. Yet there was nothing in the history or accompanying symptoms to support the diagnosis. So firmly convinced were my friends as to the nature of the disease, that in spite of my expression of doubt the patient was taken into a home for inunction-treatment, and there salivated. I was assured that when she was finally under the influence of mercury the throat got almost well; but most certainly when she again consulted me some months later it was as bad as ever, and so it remained to my personal knowledge, in spite of all treatment, for several years. I have seen this patient at intervals for at least five years. She still has her sore throat, but nothing has occurred to corroborate the diagnosis of syphilis. Had the throat been specific, I feel sure that it would have got either well or much worse long before this. As to its nature and cause, I am not prepared to give an opinion. It was a most unusual case.

I have recently seen, at the instance of Dr. Fenton, another patient whose mouth reminded me of the preceding. The alveolus, cheek-pouch and part of palate were in a state of chronic inflammation, with ulcers and much formation of white pellicle. The patient was again a young single woman, and there was nothing whatever to support the suggestion of syphilis. It differed from the preceding case in that the conditions were on one side only, whereas in the other they were symmetrical.

In the case of a lad whom I saw at Maidstone in consultation with Dr. Ground, there had been a sore throat with

numerous nodes and an eruption. Yet there was no proof of syphilis, and the patient was not cured by specifics. The stages of development did not in this case fit with the syphilitic hypothesis, and the patient finally died of gangrenous pneumonia. Some potent influence inducing blood changes was evidently at work, but I doubt much whether it was the poison of syphilis. (ARCHIVES IV., page 4.)

The remark last made applies to the Leeds vaccination case, and to another which I recorded at the same time, in which gangrene of the vaccination sores, with periosteal swellings, occurred. In one of these the vaccination was from the calf, and the whole of the collateral evidence opposed the diagnosis of syphilis. (ARCHIVES I., 106.)

A yet more conclusive case in proof that periosteal nodes may attend vaccination fever with gangrenous pocks occurred in the case of an infant who recovered, and in whom no other indications of syphilis ever occurred. (ARCHIVES II., 215.)

In association with these facts I may remark that it is well known that multiple periostitis, with abscesses and exfoliation of bone, may follow smallpox, varicella, and both typhus and typhoid fever.

The patient whose case is sketched in the appended Schedule was brought to me on July 21, 1892, by Dr. B—— of C——. He had just returned from Aix, where he had been treated by inunction without obtaining any advantage. As regards the most painful part of his case, the loss of his eyes, so far from his having gained anything, Dr. B—— assured me that he was in a worse condition than when he went. His left eye was glaucomatous, very hard, and quite blind. The other eye had increased tension of moderate amount, and a widely dilated pupil made very irregular by adhesions. The cornea of this, the better eye, was bright, but it was exceedingly difficult to inspect the fundus owing to the large filmy capacities which occupied the media. There were evidences of neuritis, and some greyish-white patches in the choroid, but for the reasons mentioned, and because I had not much time to give for the inspection, I must not speak on these points with much definiteness.

It seemed not improbable that the long continuance of the

## SCHEDULE OF CASE.

*Inheritance of gout on both sides—Good health till the age of 16—A severe sore throat with sore tongue—Many relapses—Syphilis suspected—At the age of 22 pustular ophthalmia followed by double optic neuritis, iritis, and destructive ophthalmitis—Renewed diagnosis of syphilis, and long-continued specific treatment—Imperfect results—Loss of both eyes—Death from strumous pneumonia at the age of 25.*

AGE.	DATE.	DETAILS.
16	1884	In December of this year he had a very troublesome sore throat, which was at first supposed to be connected with scarlet fever, but which was not attended by any eruption. There was no proof of contagion of syphilis.
17	1885	The sore throat continued, and sores on the lips and sides of tongue having excited suspicion of syphilis, a consultation was had. The consultant attributed the sore mouth to bad drains, and opposed the idea of syphilis. Many specialists were afterwards consulted, and none prescribed for syphilis.
18	1886	A discharge from the nose occurred. The sores in the mouth continued to recur. Mercury and iodides prescribed.
19	1887	His throat frequently relapsed. He was out of health and liable to a pustular and lichenoid eruption which was called acne.
20	1888	Still liable to relapses of sore mouth.
21	1889	The same liabilities persisted. The diagnosis of syphilis had been long abandoned, and no specific treatment was now used.
22	1890	Liable to swellings on shins (like nodes), and to painful swellings in muscles, which seldom lasted more than a few days. Superficial ulcerations of corneæ.
23	1891	21st of January first seen by his present medical attendant, Dr. B—. The group of symptoms, sore mouth, multiform eruptions, &c., led to a confident diagnosis of syphilis. Double optic neuritis was diagnosed positively as of syphilitic nature. Vigorous specific treatment was begun, and continued for long periods.
24	1892	No improvement obtained, but periodic attacks of kerato-iritis with hypopyon and vitreous opacities. Three ophthalmic specialists confirmed the diagnosis of syphilis. In May sent to Aix, when inunction was employed.
25	1893	Death from strumous pneumonia. In October.



use of atropine was responsible for the increased tension of both eyes. The left eye presented a typical condition of advanced glaucoma, the whole cornea being steamy, and the large pupil presenting a dull, greenish yellow reflex. It was quite impossible in this eye to examine the fundus.

The patient was exceedingly pale and feeble-looking, with chilly extremities. He had on his forehead an indefinite lichenoid eruption, and on his shoulders and back were numerous reddish or livid scars and stains. On many parts of the limbs and body there were groups of spots of lichenoid or acneoid character. About the nature of this eruption it was impossible to say anything definite, more especially as he had during the last year taken much iodide of potassium, which might have produced it. Some of the scars were, I was told, consequent on abscesses after hyperdermic injections. On inspecting the throat I found nowhere any evidences of deep ulceration. The pharynx and sides of palate were pale and patchy, as if superficially scarred, but there was no present ulceration, nor any alterations of contour. On the sides of the tongue were some indistinct filmy grey patches.

There was nothing either in the condition of the skin or the state of the mucous membrane of the mouth or the throat which, if it had not been suggested beforehand, would have led me to suspect specific disease. I had been informed that there had been transitory evidences of periostitis on the tibiæ, and some slight thickening was certainly present on one of them. It was, however, very limited, and the rest of the bone was quite smooth. The lumps which had occurred in muscles and cellular tissue were described as having been very transitory, having usually lasted only a few days. One of these on the side of the left calf was present when the patient was with me. It was an ill-defined, elongated, tender swelling, about as long and as thick as a large thumb, and adherent to the muscle, but possibly not developed in its substance. It had been present only a few days, and was expected to disappear quickly.

The history of what had occurred in the eyes, the repeated relapses of kerato-iritis, the production of vitreous opacities,

made me suspect that we had to do with a case of inherited gout, complicated probably with scrofula. On inquiring as to the family history, I learnt that gout had declared itself strongly on both sides of the patient's family. A paternal uncle who came with him had himself suffered several acute attacks, and he said that another brother was crippled with rheumatic gout, and that their father (the patient's grandfather) had also suffered. On the mother's side there were equally strong facts, and a near relative had died of phthisis. The patient had several brothers and sisters who were in good health.

In reviewing the evidence in this very complicated and obscure case, I arrived at a strong impression that inherited gout was at any rate one very important factor. It, and it alone, would, so far as I know, explain the recurrent and destructive forms of inflammation which had occurred in the eyes. The glaucomatous complication I was disposed to think owing to the long-continued use of atropine, which had been employed with the object of preventing adhesions. In several similar cases in young persons I have observed a remarkable tendency to increase of tension from atropine, and have been obliged to disuse it. Respecting the eruption which had developed on the skin, it is not necessary to be very precise. It had been regarded in the first instance, and probably with reason, as acne, and it had been subsequently complicated by the use of iodides. The swellings in the cellular tissue, or muscles, and those on the periosteum of the tibiæ, had been of much more transitory character than is usual with specific gummata. We have, lastly, the state of the mouth. This it is perhaps difficult to connect in any way with gout, but at the same time it must be asserted that nothing really characteristic of specific disease had shown itself at any stage. The theory of syphilis was that a sore on the lip had been contracted accidentally (smoking, &c.) in 1885, and that the disease had proved so persistent in the mouth because that was the part first affected. Against this, however, was the fact that during the first and long persisting sore throat there was no eruption whatever; that although at different times several surgeons had diagnosed the mouth as

syphilitic, others (the majority) had held a different opinion; and lastly, that it is an occurrence almost unknown in the history of syphilitic throats for disease to persist and to relapse for five years without assuming a tertiary character, and causing destructive ulceration. Nor is the entire failure of specific treatment as a cure without its significance. During a year and half prior to my consultation mercury and iodides had been used with great vigour. Mercury had been given by the mouth, by inunction, and by hypodermic injection. When the optic neuritis appeared three ophthalmic authorities pronounced definitely for syphilis, and the patient was made to keep his room and use inunction most liberally. Unless, perhaps, we consider that the throat healed under the influence of these measures nothing was gained. The eyes became worse, and respecting the throat and mouth it is to be remembered that cures and relapses had been occurring under various treatment for upwards of four years.

Against the diagnosis of syphilis we had—

The absence of any known chancre.

The absence of any secondary eruption.

The very long persistence of the sore throat.

The judgment given by several surgeons at different stages that the sore throat was not a specific one.

The course taken by the ophthalmitis.

The inefficiency of specifics.

For the diagnosis of syphilis we had—

The judgment of several surgeons that the ulcers in the mouth and throat presented characteristic features.

The judgment of three ophthalmic surgeons that the optic neuritis was characteristically specific.

The occurrence of periostitis.

The cure of the sore throat, &c., apparently by specifics.

For the diagnosis of inherited gout we had—

The strong family history.

The relapsing character of all the phenomena.

The destructive nature of the ophthalmitis.

The close conformity of the disease in the eyes with what is well known in connection with gout in young persons.

*(To be continued.)*

## LENTIGO-MELANOSIS.

### A FURTHER REPORT.

AT page 319 of ARCHIVES, Vol. III., will be found the particulars of a case in which, in a lady of sixty, senile freckles on the lower eyelid had advanced to condition of melanotic staining. I now revert to the case in order to add some additional facts of considerable importance. During the two years which have elapsed the staining has very slowly advanced, and there has also occurred (as in some other cases) a malignant growth on the edge of the lid. This is exactly what happened in the case of Sir A. D., which I published at the same time (p. 320). The two cases are the exact repetitions of each other. In both the melanotic staining had been slowly aggressive for many years before any tendency to malignant new growth showed itself, and in both the latter, when it did occur, developed rather rapidly and was marked by a non-pigmented structure.

I am now able to produce a portrait (see Plate) which will enable the reader far better than any description to realise what is meant. The middle figure in Plate CVI. shows the eyelids of the patient whose case I now supplement. In the lower left-hand figure the same eye is shown with the lid drawn down so as to exhibit the staining of the conjunctiva and margin of cornea. This condition had been attained by slow spreading and coalescence of what at first looked like dark freckles during six years, or possibly much longer. The portrait was taken in 1892. In June of 1893 the patient came to me with an ulcerated growth involving the middle of the edge of the lid. It was as big as the tip of one's little finger, and had developed in the course of about two months.

There was no gland disease. I had no hesitation in advising its immediate excision. Having first asked my patient to show her curious lesion to Sir James Paget, I freely removed a V-shaped portion of the lid. The wound healed at once, and as yet there has been no recurrence.

The operation afforded an opportunity for microscopic examination, and I now append a report by my eldest son of the results obtained. No. 1 refers to the growth, and 2 to the melanoid skin adjacent to it.

*Report on Case of Melanotic Staining of Eyelid with a Sarcomatous growth (by Jonathan Hutchinson, Junr., F.R.C.S.).*

Sections were cut at right angles to the surface so as to traverse both skin and mucous membrane, and on microscopic examination the following points were made out.

1. In the centre of the lid, *i.e.*, at equal distances from the skin and conjunctiva, a mass of deeply pigmented cells was found, the pigment occurring as fine brown granules, or sometimes as black masses filling the cells. The latter were of very varying size and shape, frequently spindle-like, but as a rule rounded or oval. Some were so large as to suggest an epithelial nature, and here and there groups of them were surrounded by a connective tissue capsule, so that the appearance was not unlike some form of cancer. Nevertheless, on the whole, the nature of the infiltration seemed to be clearly sarcomatous. This was most evident, perhaps, towards the periphery, where the fibres of the orbicularis muscle were invaded. At the centre all trace of muscle had disappeared. The Meibomian and other glands on the conjunctival surface of the growth were little affected, in fact appeared to be quite normal, and the same may be said of the cutaneous sweat and sebaceous glands. The process of invasion of individual striped muscle fibre by the various cells could be clearly traced, columns of the latter growing up inside the sarcolemma so as to completely fill it. Only a small portion of the central mass was pigmented, the densest colour being found towards its centre, as is generally the case with melanotic sarcoma.

2. Pigment was found in the sections in two other situations than the central new growth ; first as a thin layer of pyriform or oval cells just below the conjunctival epithelium, but quite distinct from the latter ; and secondly in a similar situation on the cutaneous surface. The epithelium in both places was practically free from pigment.

*Comments on the Group of Cases.*

In the uppermost of the figures in Plate CVI. are shown the eyelids from another patient affected by the same malady, but with some minor differences. In nearly all the cases which I have seen (counting, if I may reckon some in early stages, about ten) the pigmentation has much preponderated on the right side. This is the reverse of the law in xanthelasma of the eyelids. In the portrait now given, however, the left eyelids show the largest and blackest freckles. The malignant growth also, instead of being on the edge of the lid and in the middle of the stained patch, is on the skin of the lid at some little distance both from its edge and from the black patches. It is itself wholly free from pigment. I have seen another case which exactly repeated these conditions.

Apart from the importance of their clinical recognition, much interest appears to me to attach to this group of cases as illustrating the laws under which physiological processes slide into malignancy. We have first freckles such as are seen on the eyelids of many elderly persons, these become very black and enlarge. Next the freckles coalesce, and we have a patch which is infective at its edges, and which may extend to the adjacent mucous membrane and even to the cornea of the eye. Still there is nothing to be called new growth, the process being simply one of pigmentary staining without appreciable thickening. Lastly, however, another stage is assumed, and a growth takes place which is for the most part unpigmented, and which in its tendency to break down and ulcerate reveals its malignant nature. In some cases this final growth is of epitheliomatous structure, and in others sarcomatous.

This form of disease is not limited to the eyelids, although

its most typical examples are seen on them. I have already described examples of it on the lips and on the prepuce. Since I last wrote on the subject, I have also found in Bruns' Atlas a figure which appears to show this condition on the lower lip. The melanoid staining is extensive, and the new growth of considerable size and thickness.

## PLATE CVI.

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### SENILE FRECKLES.—MELANOTIC STAINING.— EPITHELIAL CANCER.

THE uppermost figure in this Plate represents the condition of the eyelids in Mrs. P. L., whose case was given in 'Archives,' vol. iii., p. 321. She was the subject of senile freckles, which on the left side had advanced to a condition of melanotic staining, and were accompanied by a small, unpigmented epithelial growth. This latter growth is seen on the lower eyelid under its outer half. The pigment patches, which are near it, were gradually extending. It will be seen that on the eyelid of the opposite side there are some slightly-marked patches of pigment staining. Some treatment by scraping had been practised for the cure of the epithelial growth before I saw the patient. I had some doubt as to whether the little nodules shown in the portrait were not of the nature of keloid; but as the patient passed from under my care, I had no opportunity of making a microscopic examination.

The central figure shows the state of the eyelids in another lady of about the same age as in the preceding case (sixty-two years). It will be seen that the lower eyelid is very extensively pigmented. The stained part was mostly but little, if at all, thickened. The pigmentation was definitely aggressive, and has extended very considerably during the three years that the patient has been under my observation. There is little or nothing on the opposite eyelids which can be counted as senile freckles; but it will be seen that there is a little *nævus* very near to the edge of the lid. A similar and larger *nævus* is seen just over the inner canthus on the right side.

The left-hand lowest figure represents the eye of the same patient as the preceding, at a somewhat later stage. The lower eyelid has been drawn down, in order to show that the conjunctiva and even the cornea itself are pigment stained. At the present date.



PLATE CVI. (*continued*).

two years after this sketch, the conjunctiva has become of a very deep brown, and in the cornea a narrow margin of sepia tint, affecting the arcus senilis, has extended round almost the entire circle. Only a very small portion of the corneal rim, in the middle line under the upper lid, is now free from staining. After watching this case for three years, much in the condition shown in the sketch, I have recently had to excise a portion of the lower lid on account of an epitheliomatous growth close to the edge, which, although still of small size, was developing rapidly. It was not pigmented. I have not attempted to remove the pigmented parts, as it will be seen that not only the eye itself, but the upper lid also is involved.

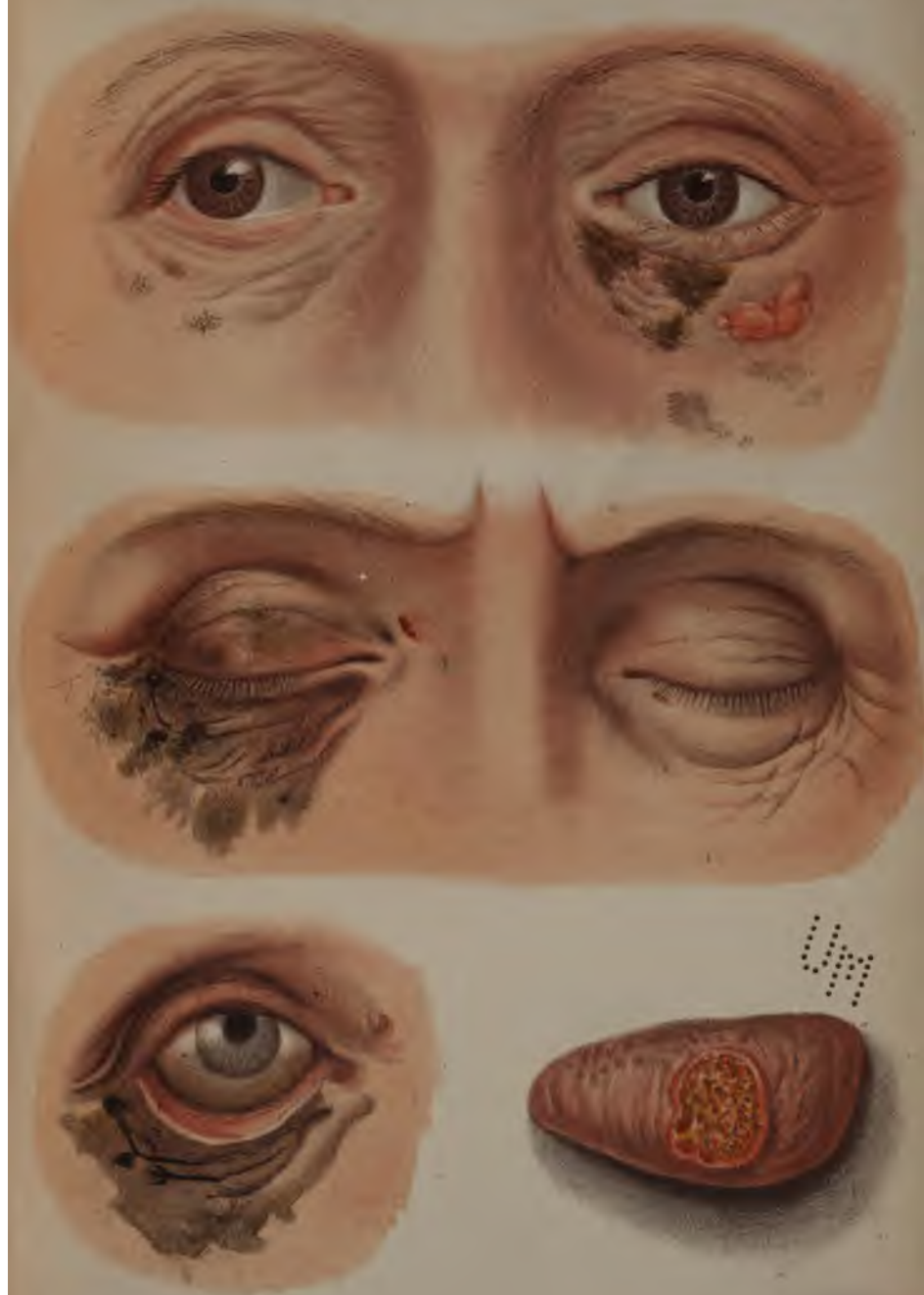
EARLY STAGE OF EPITHELIOMA OF THE TONGUE.

The right-hand lowest figure shows the portion of the tongue, which I excised in the case of the late Mr. K. The little ulcer here shown had formed in connection with a sharp tooth, when Mr. K. was sent to me by his dentist. The characters of the ulcer are well shown. It was small, clean and quite superficial; but it had a rolled edge, and a slightly hardened base. It had been present only a few weeks. The sketch, which was made after the operation, will prove that I excised it freely. No return of the disease ever took place in the tongue itself; but the patient died two years later from secondary disease of the glands of the neck.

This sketch may, I hope, prove useful in assisting towards the diagnosis of cancer of the tongue at an earlier stage than is usual. Perhaps cancer of the tongue was never in any case excised, whilst apparently so insignificant or under conditions apparently so hopeful as to permanency of recovery. Yet, as has been shown, the lymphatics were already infected.



1. The first part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".





## DISEASES OF THE NERVOUS SYSTEM.

No. LXIV.—*Slow and imperfect mental development—Defective formation of Nails and Hair—History of a very prolonged birth with nearly fatal results to the infant.*

There are some interesting points in the following case:—Mrs. C——'s child was sent to me with the double diagnosis of cretinism and rickets. Probably it had but little relation to either. The child, a girl nine years old, had an idiotic expression and a large head and face. Her cheeks were very full; the lower lip projected and the tongue was constantly partially protruded. The nose was flat. Her expression was that of placid stupidity; but her mother assured me that she was "a lot sharper than you would think to look at her," and that, when quiet at home, she could say almost anything. She never made the least attempt at speech in my presence; but she was quite docile during a long ophthalmoscopic examination. It was very difficult to get her to fix her eyes on anything. She could but just manage to walk in a weak, waggling fashion. Her scalp hair was very thin, weak, and scanty, and I was told that her nails had formerly been very small and weak. Of late they had much improved. Her hearing and sight appeared to be perfect. I was told she was very cleanly in her habits, and that though formerly she used to cry a great deal, she now but seldom did so. The circumference of her head was 20 in., the measurement from ear to ear being  $12\frac{1}{2}$ . Her mother had other healthy children. The history given was that her birth was by a breech presentation and a very prolonged difficult labour; that she lay for several days between dead and alive, but that finally she

appeared to thrive pretty well during the first year of infancy. She was considered to be a restless baby; but it was not till the end of the first year that the mother took any alarm as to her mental condition. She was very slow in learning both to walk and to speak. At the age of two she could only say one or two words; she did not walk till she was six.

It appeared to be a case in which both the mental powers and the ability to use the limbs were gradually improving.

It does not seem unreasonable to suspect that in this case general defect in the child's nervous system was induced by the influence of the very prolonged labour upon the circulation in the brain. It is clear that this all but caused death.

No. LXV.—*Fatal Tetanus after plugging of the nostrils for Epistaxis.*

The following are the particulars of a case in which a man died from tetanus in consequence of plugging of the nostrils. I saw Mr. B——, a gentleman aged 60, in October, 1865, in consultation with Dr. Evans. The reason for our meeting was that symptoms of tetanus had set in, and that it had been found impracticable to remove some plugs from his nostrils, which had been put in ten days before. The history given was that he had suffered from such profuse epistaxis that he was quite blanched. Dr. Evans, having tried various other remedies, finally plugged both nostrils with sponge. Silk ligatures were, as usual, attached to the sponge; but the plugs had become so firmly fixed that no ordinary force could dislodge them. The plugging was done on September 30th, and I met Dr. Evans and the late Dr. Habershon in consultation on October 10th. The patient then had definite trismus, which had been present forty-eight hours. He had spasms, and had bitten his tongue more than once. We administered chloroform, and I then with forceps took out the plugs, which were very firmly fixed. No bleeding occurred. The trismus continued, and although there was no great increase in the tetanic spasms, the patient sank during the following night. I was told that he had enjoyed

good health before the attack of epistaxis, which was the first that he had ever had.

This case is of interest, not only as an example of fatal tetanus from an unusual cause, but as exemplifying the occasional dangers and inconveniences which may result from plugging the nostrils. For many years I have never in any single instance adopted this practice; and the case narrated was one, with others, which gave me a great prejudice against it. Without, however, laying undue stress on the fact that the plugs, if large and efficient, are not unfrequently very difficult to remove, I may allege as a much stronger reason against the practice that it is wholly unnecessary. Since I have adopted the practice of placing patients with severe epistaxis in the sitting position and with the feet in a deep foot-pan of very hot water, I have never once failed in arresting the bleeding. I have, in one or two cases, continued the pediluvium for several hours, and never with any inconvenience.

No. LXVI.—*Paralysis Agitans affecting the Right Limbs only.*

Mr. G——, a gentleman whom I treated twenty-five years ago for chronic strumous disease of one elbow joint, and who recovered (under cayenne pepper) with complete ankylosis of the ulna and humerus, has recently consulted me for new symptoms. He is now (June 29, 1891) the subject of a curious form of paralysis agitans, which affects the right limbs only. Both the upper and the lower limb are usually involved in shaking at the same time; thus if he attempts to use his right hand, both hand and foot begin to shake. His right foot is always shaking when he is at meals or attempting to write. There is nothing amiss with the left limbs. He thinks that the right limbs are always colder than the others, and, as far as he observed, the shaking began only six months ago. Any slight excitement causes these limbs to shake. Mr. G—— is a well preserved and intelligent man, aged 57.

In reference to his elbow joint, I may note that the limb



him, was the most conclusive point of all that the brush had nothing to do with it, since herpes always takes a few days for its development.

I may just add that this case was a remarkable instance of severe herpes in a man past middle age with little or no pain. The man denied that any pain had preceded the eruption, and although for a few days, at the height of the inflammation, the scalp had been very sore, it had quite passed off when I saw him at the end of eighteen days.

No. LXVIII.—*Case of Shingles attended by general Eruption.*

As is well known, herpetic inflammations have no tendency to affect the adjacent skin, and never spread. A very extraordinary seeming exception to this came under my notice in the person of a gentleman from — named S—, aged 53. Three weeks before I saw him (May 20, 1893), whilst in excellent health, he had begun to experience a pricking in his back and arm, for which he consulted a medical man, who prescribed arsenic. From his account I should think the herpes was just coming out at the time, and should not incline to attribute the latter to the arsenic. When I was consulted there were large groups of scars, extending from the middle of his back across the lower angle of the scapula and round the front of the chest. These were characteristically those of herpes zoster, but were unusually florid and irritable looking. The remarkable point of the case was, however, that all over the neighbouring parts of the chest, shoulders, and arm, there was a plentiful crop of a pustular eruption almost like that caused by antimony. I thought that some irritant must have been applied for the cure of the herpes; but he assured me that he had used nothing stronger than vaseline. There were a few scattered pustules on the upper part of the arm on the opposite side. The arsenic, for which he brought me the prescription, had been prescribed, on May 9th, in five-minim doses of Fowler's solution. This was eleven days before I saw the patient. It seems scarcely probable that arsenic could have produced the

scattered pustular rash just described, but it is not unlikely that it had been a means of delaying the healing of the herpes, seeing that its administration had been commenced at a time when the latter was fully out. I do not think that I have ever witnessed a similar occurrence.

No. LXIX.—*Recurring Herpes on the same spot on one thigh—Possibly Gouty.*

A gentleman named H—, aged 40, whom I had treated twenty years ago for syphilis, and who had remained apparently quite well, became liable to a patch of herpes on the outer part of his right thigh, which recurred almost exactly on the same spot in the spring of every year on seven occasions. Now and then it would occur in the autumn also. He was never especially ill, but he considered the spring as the worst time of year for him. In the spring of 1893 his herpes did not occur, but he had a troublesome attack of rheumatic sclerotitis, which during several weeks changed from one eye to the other. He was of gouty family, and of liberal habits of life.

No. LXX.—*Occipital pain after sexual intercourse—Epileptiform insensibility.*

A man who consulted me (July 19, 1875) on account of exostosis of the upper jaw, told me, in discussion as to his general health, that, for several years before his wife died, sexual intercourse had such an injurious influence upon him, that he had entirely avoided it. Immediately on the completion of the act, he experienced "a dreadful sensation in the back of the head" as if he would die, and became for a few minutes unconscious. He always managed to conceal it from his wife, but the attacks alarmed him so much that he determined to entirely abstain. Instead of telling his wife, he made business his excuse for living in another town, and never afterwards saw her except in the presence of one of their daughters. He took the latter precaution because, his appetite having by no means left him, he was

afraid of being tempted to break his rule. Other patients have told me of similar symptoms though with less emphasis.

No. LXXI.—*Hysterical Aphonia—Sudden and complete recovery.*

The following facts are of much interest in reference to temporary suspension of nerve function in connection with the hysterical temperament. In April, 1875, I was attending Capt. C——, who was nearly blind, and used to hear frequently from his wife her regret that, owing to her loss of voice, she could not, as was her custom, read to him. For a month or six weeks she never spoke louder than a whisper. She had had several similar attacks of nervous aphonia. Suddenly one day I found her speaking with a loud, clear voice, and in great delight that her voice had returned. She said she could read for an hour together quite easily. On inquiry as to what treatment had been successful, she told me that she did not attribute her improvement in the least to the remedies employed. One morning, while dressing in a hurry, she had broken her stay lace, and, in the excitement of the moment, she exclaimed, "Oh bother!" in a clear voice. From that time she continued able to speak quite well. I cannot think that in this case there was any organic disease or any attempt at malingering. Possibly, in the beginning, some slight catarrhal affection of the larynx might have been present; and there remained afterwards an inability on the part of the will to again arouse the muscles, which had partially failed in function.

There were other facts of great interest in Mrs. C——'s life history. I asked her if she had ever been hysterical, and she said, "Oh, yes, before my marriage often so." After her marriage also on one occasion, when very anxious on account of her husband's illness, she one morning got out of bed to get him some medicine, and suddenly lost the use of her limbs on one side. The hand and leg became numb, and her face, she says, was distorted. She well remembers that she could not feel, as she says, in the least, in either the upper or lower extremity, whilst her attendants were rubbing

them. Great alarm was occasioned by this attack, but in a few days she entirely recovered. She has always considered herself a very nervous person, but has had no serious disease. She is a stout, comfortable-looking person, aged about 50, the mother of several children.

## THERAPEUTICS.

### No. XXXIX.—*Report of results from Excision of Diffuse Lipomata—Use of Sulphide of Calcium.*

IN ARCHIVES, Vol. III., p. 194, I have recorded a case in which I had treated a case of diffuse lipomata of enormous size by operation. Very large masses of fat had been excised from the back and sides of the neck. I have recently seen this again, and can now report the result after three years' interval. It has been excellent. Formerly the patient was unable, on account of the grotesque disfigurement, to go into society; now there is nothing to be seen which would excite notice. He looks somewhat full about the claps, but that is all. The back of his neck is of normal contour. There has not been the slightest reproduction of fat where the masses were excised. I did not at the operation remove nearly the whole of the growth. Those under the lower jaw and in front of the neck were left untouched, as if I had meddled with them I should have had to skin the whole neck. During the three years there has been decided and steady diminution of these also. Soon after the parts were healed from the operation, the neck measured in girth twenty-three inches. It now measures only seventeen. At three stages he has had to reduce the size of his collars. Three different influences may have contributed to this result. He has recently in connection with liver disease, possibly malignant, lost flesh and fat generally. I do not think that this accounts for much, because the diminution was observed to be in progress two years ago. The chief influence has been, I believe, the steady use of sulphide of calcium. He has taken one-grain pills of this salt twice a day, almost continuously. Messrs.

Richardson, of Leicester, who make these pills as a specialty, inform me that they have supplied seven gross in little more than two years. The patient himself is firmly convinced that the pills have had great influence in reducing the size of his neck, and it is to be observed that although I enjoined abstinence from beer and extreme moderation in stimulants, he has not been strict in this matter. He admits having had one glass of beer a day. I inquired whether the pills thus continued for so long a time had shown any influence on his general health. He said: "None but good." He had been in much better health than formerly. Irritation at the anus was, he thought, the only inconvenience which they ever produced. He has now cirrhosis of the liver, and some symptoms which suggest malignant disease of the stomach.

No. XL.—*Use of Opium in Incurable Disease.*

There are circumstances under which the opium habit is not to be shunned. In those who are the subjects of incurable disease of a painful character, and who are not likely to live more than a few months, the free use of opium is permissible, and adds greatly to the comfort of life. Thus, in cancer cases which are beyond hope of relief, I never scruple to recommend opium in any form that agrees, and in any dose that is required. It is an invaluable remedy. It is not in all cases that increase of doses is necessary, but should such be the case we need not hesitate. If life is not to be extended over more than three months, the habit will not be attended by the ill-consequences which so often outweigh the benefits in protracted cases. It is cruel to forbid nepenthe or morphia under such circumstances.

No. XLI.—*Arsenic as a Cause of Herpes Zoster.*

I observe that Dr. Railton, of Manchester, has been treating chorea in children with very large doses of arsenic. He gave fifteen drops every eight hours. Several of his patients suffered from the symptoms of peripheral neuritis, to which others as well as myself have repeatedly drawn attention as

occasional consequences from this drug. I am personally interested more especially in his statement that three had shingles. As the total number so treated was only nine, we have a very strong confirmation of the opinion that arsenic can cause herpes.\*

No. XLII.—*The Relief of Tabetic Pains.*

A physician, himself the patient, told me that for the relief of the pains of tabes he had found phenacetin the best remedy. He was accustomed to take it in fifteen-grain doses, putting the powder on his tongue. This dose he would take every four or six hours when the pains were severe. He had formerly tried antipyrin with great relief, but with, he thought, the result of inducing some debility. It made him perspire, and also made his lips blue from retarded venous circulation. I have myself usually been in the habit of prescribing antipyrin for this object, and have not met with much if any inconvenience from it. Morphia is, of course, the most effectual of all; but its effects are so pleasant, that it almost always induces habitual use and increase of dose. It is to be most emphatically avoided by all tabetics.

No. XLIII.—*A Patient's choice of Hypnotics.*

A non-medical friend of my own was an expert in hypnotics, having suffered much from insomnia, and having had advice from many medical friends. He finally came to anchor on opium and chloral, not taken together, but in separate doses with a two hours' interval. His dose was one to two grains of opium before going to bed, and a drachm of the syrup of chloral an hour after getting into bed. He had previously found that chloral alone did not agree, but with the combination referred to he had not failed during the last two years of his life to procure a fair night with refreshing sleep and no inconvenience on waking. He had not found it needful to make any increase of the doses, and congratulated

\* See a paper by Dr. Neilson in a recent volume of Dermatological Papers published by the New Sydenham Society.

which in some persons agrees too well and creates an appetite for more. Thinking and writing as medical men we must, however, deal with the facts as they are, and place our knowledge fully and honestly at the disposal of the public. No good can come of concealment of the truth. Let us devise such precautions as are needful with a full and clear knowledge of our real position.

No. XLVII.—*Acute poisoning by Iodides—Edema of pharynx the first symptom.*

I ordered for a lady, who much needed it, a mixture containing, together with a drachm of the solution of mercury, four grains of the iodide of potassium and two of the iodide of sodium. These ingredients, together with a drachm of tincture of bark and two drops of Battley, made up the dose which she was to take three times a day. She took but two doses, when she was seized by a sense of constriction and swelling in the throat, followed by general soreness of mouth and lips, and in the course of a few hours by burning of the whole skin and an eruption of large erythematous wheals over the limbs and body. She passed a sleepless night in extreme discomfort, and the next morning was so ill that her husband insisted that I should come to see her. She had been liable to nettlerash before. The eruption took the form of patches of erythema as large as the outspread hand, which occurred on the neck, face, chest, and thighs. They differed from nettlerash in not being pale in the centre, and also in being persistent and larger and more raised than is usual in that disease. It was quite obvious that the whole was due to the iodides, and within a few days all the symptoms had disappeared. I examined the urine, but there was no proof of renal incompetency.

The symptom of swelling in the throat as the earliest indication of iodide poisoning has been noticed in other cases. I remember that of a man brought into the London Hospital in whom tracheotomy was only just in time to save his life. Nor is the promptness with which the acute symptoms showed themselves any exception to rule. In those who are liable



to iodide-poisoning it is a matter of mere idiosyncrasy, and neither dose nor time have anything to do with it. The symptoms set in immediately after the drug is given, and may be very severe after a very small dose. I have thought the case worthy of record, although not exceptional, because it affords an important clinical lesson.

No. XLVIII.—*Cirrhosis of the liver in a boy—  
Recovery.*

A young man, aged 28, brought his father to me. It was incidentally mentioned that nineteen years ago I had treated the younger man himself, then a boy of nine. I was told that I had cured him of a "drunkard's liver." This diagnosis I found was not mine, but that of a distinguished physician who had seen the case before I did, and who told the boy's father that he had seen only one other similar case (*i.e.*, cirrhosis of liver) in a child. There had not been any previous abuse of alcohol. I found that the man was still taking the prescription which I had given him so long ago, and that he believed it to be "the only thing which would touch his liver." He was now in fair health, but still liable to dyspepsia. As a boy it had been expected that he would die, and he was for long an invalid. I was of course curious to know what the prescription contained which had worked such wonders. It was subsequently sent to me, and I found that it was not mercury, but taraxacum and nuxvomica together.

dermatitis is more diffuse and affects the backs of the fingers as well as the fronts, then the nails usually suffer.

No. LXXIII.—*Syphilitic Sycosis-Lupus of the upper lip simulating Rhino-Scleroma.*

Mr. P——, aged 36, from Dr. C—— of P——, afforded a good type example of syphilitic sycosis-lupus, located on upper lip, and caused by discharge from the nostrils.

He was sent to me as an example of lupus vulgaris, and scraping had been advised. The ragged character of the patch and the absence of "apple jelly" made me feel certain that there was syphilis in the case. The patch involved the part of upper lip immediately beneath the nostrils, and hairs of the moustache had been almost wholly destroyed. There was much lumpy thickening covered by dry adherent crusts, which could not be removed without causing bleeding. It might be counted as a form of syphilitic rhino-scleroma. It had been slowly spreading for eighteen months.

Mr. P—— admitted gonorrhoea eight years ago, and about the same time had warts under the prepuce. He was never treated for syphilis, so far as he knows. He had had, two or three years ago, an ulcer on his scalp, much like that now present on his lip, which has healed and left a scar. It lasted twelve months, and he was under many doctors.

I have ventured in the above heading to give a partnership name to a partnership malady. The disease was doubtless, in a sense, syphilitic—that is, the patient's state of nutrition and his proclivities had been modified by a former attack of syphilis. Probably, however, he would never have had the sore on his lip had it not been for the irritation caused by catarrhal defluxion from his nose. We encounter many troublesome cases of chronic sycosis of the upper lip which originate and are perpetuated by this simple cause. A few of these may, if utterly neglected as to treatment, and especially if occurring to patients who inherit tendencies to both struma and cancer, run on into hypertrophic and infective conditions. It is, so far as I understand the matter, to growths acknowledging these varied elements of causation that the name Rhino-scleroma is given.

No. LXXIV.—*Xanthelasma Palpebrarum*—*The same in several of the patient's children.*

An old lady named C——, whom I saw with Mr. Benjamin Duke, was an interesting example of the family and hereditary prevalence of xanthelasma. She was sixty-four years of age, and had large patches of xanthelasma of characteristic colour, but extremely thin in substance, on both sides. They were quite symmetrical, and on both sides there were little patches at the outer canthus, as well as large ones around the inner. The history was that she had had them slowly increasing for five-and-twenty or thirty years. She had been liable to sick headaches, and on two occasions she had been all but jaundiced. She was not aware that any of her predecessors had presented the same peculiarity, but three or four of her children had them.

No. LXXV.—*Leucoderma in association with Alopecia*—*Alopecia following Ringworm.*

Mr. C. D——, aged 28, who had come from Australia (where he was born), consulted me on June 30, 1893. At the age of fourteen he had ringworm, and since then had suffered from alopecia, which had become universal. For the last fourteen years he had worn a wig. He was also the subject of leucoderma, occurring in spots and streaks on his hands and wrists and on his scrotum. Almost the whole of the latter was quite blanched, with abruptly edged patches at the root of the penis. The spots on the hands were small and indefinite. The lower eyelids were bleached, at their outer canthi, in patches with abrupt edges.

Mr. D—— informed me that he believed there was much ringworm in Australia. Probably there was no connection whatever between the alopecia and the leucoderma.

No. LXXVI.—*Peculiar conditions of Congestion of the Nail-bed.*

In many persons there may be noticed an ill-defined border just below the free edge of the nail which is of a deeper tint

than the rest of the nail-bed. Perhaps most persons can by pressure of the finger ends on some hard body make this line conspicuous. In some conditions of feeble health the border to which I refer becomes much exaggerated, and of a livid purple tint. I have just noticed it (May 17, 1893) in the fingers of a lady, aged thirty-seven, who recovered six months ago from a severe miscarriage, and who suffers from nervousness amounting almost to decided depression. Although not apparently out of health in other respects, her circulation is feeble; and on her hands, and especially on her fingers, there are many little scars and purplish spots. She complained much of headaches, chiefly in the back of the head, which made her "giddy and stupid." There was a perforation of the septum nasi at the usual place just within the nostrils, which would have admitted the end of the little finger. Its edges were soundly healed; and, being associated with chilblain-scars on her fingers, I am inclined to think that it was of lupoid character, and not syphilitic. There was no reason to suspect syphilis. As regards the purplish border of the nails,—the symptom which has induced me to narrate the case,—my impression is that it is an illustration of feeble venous circulation.

No. LXXVII.—*Long persisting and recurring  
Eruptions from the Bites of Insects.*

It is always of much interest to trace the influence of known and simple causes in the production of disease. That the bites of insects assume a rôle in reference to certain chronic forms of skin-disease of a far more important character than is usually suspected, is a proposition to which I have very frequently invited attention. Flea bites are a very common cause in children of what is allowed to take rank as prurigo or lichen urticatus. The bites of lice and fleas are, I believe, by far the commonest exciting cause of urticaria pigmentosa; and eruptions on the hands and face, which may assume a chronic or even a relapsing or recurrent type, are often caused, in the first instance, by mosquitoes or gnats. I have had many instructive opportunities for carefully studying the effects of these kinds of irritation in

the persons of intimate friends, whom I have had the opportunity of seeing frequently, and I may claim to speak from exact observation. The fact that papules, which have resulted from poisoned bites or stings, will often disappear for a time and then, after a period of weeks or even months, again become red and irritable, is one which is not so well recognised as it ought to be. I have been tempted to believe that there is a law of periodical recrudescence, which applies to almost all eruptions or isolated papules, which have ever been very irritable. Those who have had the skin made to itch by whatever cause, are often liable for long periods after to recurring attacks of irritability; although there may have been no fresh access of the exciting cause.

I have been induced to make the above remarks on the present occasion, because I have just seen a case which remarkably well exemplifies them.

A very intelligent gentleman came to me this summer with his hands covered with little shotty papules, which were very irritable. They had been troubling him during most of the hot weather of the present summer, and he had also had some on his face. He told me that in the previous autumn his hands and face had been most severely stung by mosquitoes. Intense irritation had been produced, and on his hands little papules, exactly like those which he now had, were developed. During the winter he got quite rid of the irritation, but, when the warm weather came, it relapsed. He assured me that many of the papules which he now showed occupied the exact sites of those which had resulted from mosquito bites nine months ago. Yet during the present summer he had not been bitten, and prior to the attack (which occurred in Venice) he had not considered that his skin was irritable.

No. LXXVIII.—*A Case of Summer Eruption of the Acne Type.*

Miss B— has been liable to the eruption since the age of 25. She says that she is usually well in the winter; but sometimes suffers from cold winds. She is always worse in

hot weather. Any temporary exposure to sun increases it. As a girl she suffered from chilblains on the feet; but never on the hands, face, or ears. It is believed that she suffered from an eczematous eruption on the head after vaccination. The eruption on the face is very severe, and presents mixed characters of acne and eczema. On the backs of the ears and adjacent parts of cheeks, it appears to have left very superficial scars. The character of the patches is very suggestive of lupus erythematosus of the eczema type. She is clear, however, in her statement that these patches, like the others, disappear in cold weather. On her upper lip and nose the spots are not to be distinguished from those of a lichenoid type of eczema. On the eyes and cheeks, especially near to the ears, they spread into larger patches.

The eruption occurs on the backs of her hands as little isolated red papules, and does not assume the eczematous type. The conditions are exactly like those of Mrs. C—, with the difference that on the face there are patches that are distinctly eczematous. She states that on one occasion, from sitting in the sun on the seashore, the eruption came out very freely on her hands. The eruption does not occur on any other part of the body. She wears a high collar, which protects her neck from exposure.

#### No. LXXIX.—*A Note on Freckles.*

The liability to the formation of freckles must be taken as a totally different thing from proneness to receive a diffused brown tint of skin from exposure to sun. Those who brown do not blister. As Dr. Bowles has taught us, the pigmentation prevents the injurious influence of the sun's rays. The local pigmentation, which constitutes a freckle, however, and which in some instances leaves an intervening portion of skin pale, has no efficient protective influence. Patients who are much freckled not infrequently suffer from scorching also. The very tendency to freckle possibly proves an abnormal irritability of skin. I have seen this in many instances. The last which has attracted my attention is that of a Captain V—, a gentleman of light hair and blue eyes, who has

travelled much in hot countries. He came to me in August, 1893, after the extremely hot weather which we had then experienced, with both ears swollen and red and covered with little vesications and sores. This was not the thing for which he sought advice, but it attracted my attention. He himself thought nothing of it, saying that he frequently got his ears sore in hot weather. His face was covered with freckles, and on the backs of his hands they were so numerous as to be almost confluent. On his face and hands there were no actual blisters, nothing more than a little roughness of skin in parts.

No. LXXX.—*A Case of Sun Eruption on Face and Hands.*

I have lately seen a very remarkable case, illustrating the influence of exposure to sun in a child. It was indeed almost the counterpart of a case which I published in ARCHIVES about a year ago, in which an adult man from South America had become the subject first of freckles, then of vesications and eczematous irritation, and lastly of epithelial cancer, simultaneously on different parts. In the case of the boy, which I am now about to describe, conditions very much like those of rodent ulcer have been developed on the face, and although it cannot be as yet asserted that he is the subject of cancer, he is evidently in great danger of it. This boy is a native of the Cape of Good Hope, and has there been much exposed to the influence of the sun. He is of English parentage, and there is no known family inheritance. He is about nine years of age, and his cheeks and nose are covered with large scars, which have resulted in part from the disease and in part from the treatment which has been adopted. At the edges of some of these scars there are little sinuous, indurated rolls, almost exactly like those which characterise rodent ulcer. On some parts crusts are still present; but there is no tendency either to fungate or to ulcerate deeply. The only other part of the body affected is the backs of the hands, which present a condition of dry exfoliation in patches. This boy has been under much treatment in the colony, having had

the patches scraped and cauterised repeatedly under the diagnosis of lupus. This nominal diagnosis may be admitted to be not without plausibility. The boy has consulted several specialists in London, and at least one has inclined to consider the disease as lupus. Giving, as I am accustomed to do, a very wide meaning to that name, I am not disposed wholly to differ from such a diagnosis. It must be understood, however, that the conditions are essentially very different both from lupus erythematosus and lupus vulgaris, and that their cause has definitely been exposure to the influence of the sun. For those who think that lupus is always consequent on the presence of the tubercle bacillus, this disease is not lupus.

#### No. LXXXI.—*Hepatic Urticaria.*

Miss P——, a lady of forty, sent to me by Dr. Gardner, of Shrewsbury, afforded an example of what we may call hepatic urticaria. Twelve years ago, in connection with a fire, she had been much frightened, and was afterwards laid up for three months with congestion of the liver. During this attack she was yellow, but, as she believed, never deeply jaundiced. Ever since she had been liable to sudden attacks in which her skin and eyes would become yellow, with much depression of spirits and discomfort about the region of the liver. For three years she had been liable to extreme irritability of the skin, accompanied by an eruption of small red papules. Her skin was usually very dry and would bruise very easily. The eruption had usually been worst in spring and autumn. It wandered a good deal from one place to another, usually affecting the limbs, and had never been absent from the axillæ. It was worse in cold weather.

Miss P—— was of pale complexion and slightly yellow. She was easily made breathless, and complained much of lassitude. The irritation she said was intolerable, and averred that unless cured she could not support life. She had found out that fish (cod and mackerel), were poisonous to her, and that quinine and coffee disagreed. She was always worst in cold weather.



## SYPHILIS.

### No. LXIV.—*Phagedænic Ulceration of the Face in connection with Inherited Syphilis.*

One of the most deplorable cases that I have ever seen of this nature occurred in the case of a young man named H——, who was brought to me by Dr. Thorne. I was informed that the family history was complete; Dr. Thorne having known the parents and the patient from his infancy. There was, however, no need for any history, for the poor lad was absolutely deaf and had typically notched teeth. The principal feature of interest was the existence of very extensive phagedænic ulceration, involving the parts around the right orbit. The eye itself had been removed about eighteen months before I saw him, and so far as I could get at the facts, it appeared that the wound had been attacked by a sort of chronic phagedæna, which had existed to the present time. It had, however, been much aggravated of late. At the time of his visit to me, the ulcer included the entire orbit and the greater part of the cheek and forehead. It was almost exactly round and presented everywhere an abrupt elevated edge, not much unlike that of a rodent ulcer. There was, however, more of inflammation and of unhealthy secretion about it than is seen in the latter malady. The phagedænic action, however, was chronic rather than acute. The whole of the parts involved in the ulceration were considerably swollen. There was a large ulcer of a similar character, though much less severe in type, under his right ear.

There were some other facts of interest about this case apart from the chronic phagedæna which I have described. The youth was evidently the subject of a general arrest of

He was only twenty-two years of age, and had, so far as he knew, never before had syphilis. Eighteen months before he came to me, he had what were diagnosed as "soft sores" just within the meatus. They lasted two weeks or so, and were not followed by any constitutional symptoms, but during the next few months they recurred several times. Three weeks before his coming to me he had a sore on the skin of the prepuce, and almost simultaneously with it he developed a copious eruption. As he had been frequently exposed to risk of contagion, no doubt was entertained that the sore and the eruption were both of them syphilitic, and mercury in fair doses was at once commenced. He had taken it for three weeks, when he was sent to me because the eruption did not fade. I found, on examination of his penis, some little indefinite spots on the skin of its under surface. They were not indurated in the slightest degree. His eruption consisted of erythematous desquamating patches, which were scattered over his whole trunk and upper limbs. Most of them were rather abruptly defined, and it was remarkably uniform in all parts. It was much more plentiful on the trunk than on the limbs, and was very abundant on the back of the neck. There were a few very slightly marked patches on his face. I could not distinguish the eruption from a severe example of pityriasis rosea, and although there were some suspicious appearances on one tonsil, I ventured to tell him that I did not feel certain that he had syphilis, and advised him to discontinue the mercury. At his next visit, a week later, the eruption was fading everywhere, and there was nothing more characteristic in his throat. There were some little sores in one cheek that looked like herpes. A week later still the eruption had almost wholly disappeared, nothing but a slight diffuse scaliness remaining. The little sores on the skin of his penis and in the meatus had also quite disappeared.

The treatment which I had adopted was the use of sulphur baths every other day.



## PLATE CIX.

### BAZIN'S MALADY.—MULTIPLE ULCERS ON THE LEGS.

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THIS portrait represents the condition of things in Case 1, published in the 'Archives,' vol. v., page 35. The patient was a girl of thirteen, under the care of Dr. Colcott Fox, by whom another portrait, taken independently, was preserved. The girl had suffered from the ulcers of the legs for about four months. There was much dusky erythema, and the edges of the ulcers were considerably undermined. There was no reason to suspect syphilis; but there was a definite history of scrofula, both in the patient herself and her family.

[Dr. Fox has already published his portrait in the 'Dermatological Journal' for August last, and I must apologise to him for publishing another. Mine had been executed before I knew of his intention, and it seemed a pity to waste the impressions. The reader may compare them with advantage, and also read Dr. Fox's excellent paper.]









specific forms of Bazin's disease is probably ( $\alpha$ ) a scrofulous tendency, ( $\beta$ ) the peculiarities of the part as regards circulation, ( $\gamma$ ) slight injuries, pricks, stings, bruises, &c., to which the legs are especially exposed. All these influences are probably present also in the cases in which close simulations are produced during the course of syphilis. We have precisely the same problem before us as in the case of syphilitic lupus.

A very definite simulation of Bazin's malady occurred in the case of a young officer from India. His legs from the knee downward were, when I saw him, covered with sound scars. Excepting that they were more deeply pigmented at their edges, they were exactly like those of Master R—— (see plate given in last number). He had had no ulcers on other parts of his body, the disease having been wholly restricted to his legs. Some of the ulcers had, however, occurred lower down, on the ankles, than is usual in the scrofulous cases. He attributed the ulcers on his legs to local irritation, pricks, stings, &c., whilst shooting in the jungle; but they occurred at a time when he was suffering from secondary syphilis, and they were cured by specific treatment. It is, perhaps, worthy of note in this case that the patient had had, during his secondary stage, an attack of jaundice, which had cleared off well (functional jaundice). He had also become very deaf in his left ear.

No. CXXXIV.—*Alternation between Catarrhal Susceptibility and Melancholia.*

Mrs. R——, a lady of 55, usually enjoying fair health and good spirits, but liable to states bordering on melancholia, made the following interesting statements. "When I am depressed I never catch colds, and my nose is usually quite dry; I seldom need a handkerchief. But when I am well I am constantly taking cold, and frequently have attacks of sneezing and nose-running which compel me to use many handkerchiefs in a morning. The first sign of my depression state passing away is usually taking a cold." Mrs. R——'s periods



of depression had occurred four or five times when I saw her, and had more than once lasted for six or nine months continuously. She assured me repeatedly that during them she might be exposed to cold or draughts or damp to any extent, and nothing of the nature of catarrhal symptoms ever followed.

No. CXXXV.—*Epithelial cancer in the mouth in a father and son at the same age.*

Lieutenant C——s came under my observation with epithelial cancer of the hard palate. He was forty-one years of age. His father had died at exactly the same age with cancer of the tongue and secondary implication of glands. He had been seen by Sir James Paget, but too late for operation.

No. CXXXVI.—*Bold Surgery in bygone Times.*

The German Emperor Frederic III: submitted to amputation for an ulcerated leg at the age of seventy-nine. He sank after the operation (1493).

No. CXXXVII.—*Lucretius on Monsters.*

The following extract from Lucretius displays an extensive knowledge of the various forms of congenital defects in development :—

“ Some that to neither sex their title proved,  
And yet from neither sex were far removed :  
Some, short of feet, some, wanting hands, arise,  
Some without mouths, and some devoid of eyes.  
Here to lax limbs distorted limbs adhered,  
There, disproportioned all the frame appeared ;  
Cramped was each member, part with part at strife,  
And each refused the offices of life :  
To walk, to act, their nerveless powers deny.”

“ *The Nature of Things*,” Book v.

## CATALOGUE OF MEAD'S LIBRARY AND MUSEUM.

I HAVE had given me, by a medical friend who takes a laudable interest in the history of medicine, a Catalogue of the Library of Dr. Richard Mead, as arranged for sale by auction. Mead died in 1754, and the sale was in November of the fifty-fourth and April of the fifty-fifth years of the eighteenth century. The auctions of that day must have been exceedingly tedious, for the books were sold in separate lots, and no fewer than fifty-two days were taken up. The whole of the Catalogue, with its short prefaces, is in Latin. In stating the conditions of sale, however, and also in explaining some errata which had crept into the descriptions, the auctioneer has thought it best to resort to the vernacular tongue. My copy has the prices of every lot written in.

Mead had collected books of all classes, more especially in the classics and theology. The best prices obtained were for Bibles. As a rule the prices did not run high. Thus we may note that Baker's "Microscope Made Easy," 1745, sold for four-and-sixpence; Newton's "Arithmetica Universalis," Cantab., 1707, for eighteenpence; Needham's "Microscopical Discoveries," 1745, for three-and-sixpence, and a translation of the same into French for three shillings.

I believe that Messrs. Christie and Manson possess a priced catalogue of John Hunter's books, pictures, &c., which were sold by auction in their rooms. Probably other copies exist in private hands, but I never saw one. Sir James Paget in his "Hunterian Oration" quoted from the one referred to. Hunter's sale was nearly forty years later than that of Mead. It may be of interest to note that, whilst Hunter looked on the microscope almost with contempt, and ridiculed the supposed discovery of the Itch insect, Mead possessed four

microscopes designed for different purposes. The following is the auctioneer's description of them :—

MICROSCOPIUM parvum, duplicis reflexionis, a *Campani* Romæ, 1696, constructum.

ALTERUM majori forma, cum omni ejus apparatu, elegantis opificii. A *Joanne Cuff*.

Aliud cum apparatu rarii generis, nimirum camera obscura, speculo concavo vitreo, et argenteis speculis ad objecta opaca melius perlustranda. *Ab eodem artifice.*

ALIUD ad polypos, aliaque objecta aquatica contemplanda præcipue accommodatum. *Ab eodem.*

It will be seen that one of these instruments was already fifty years old, and of Italian manufacture.

The following items are of interest, as indicating the knowledge of the day and the objects which had been collected :—

Under VEGETABILIA we have—

FUNGUS marinus cerebriformis.

CAMPYLUM ramosum reticulare; Anglicè, Sea-fan.

Under ANIMALIA cum partibus eorum—

TÆNIA sive lumbricus latus.

LAPIS singularis in vesica equi repertus : pond. = 11 unc : 10 den.

HIRVDO piscis, pinnas duas habens a branchiis usque ad caudam extendentes, quarum ope aqua exiliens in aere paulisper se suspendere potest.

# ARCHIVES OF SURGERY.

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APRIL, 1894.

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## ON SYPHILITIC INFLAMMATIONS OF THE EAR.

My impression is that whilst deafness and facial paralysis, in connection with acquired syphilis, are both extremely rare, the former is rather the more frequent of the two. I have seen several very painful cases of symmetrical, absolute and permanent deafness in the secondary stage of syphilis. The complication of facial paralysis, although it occurs in exactly the same class of cases and is due to the same character of lesion, is less frequent, usually less complete and more easily recovered from, and I have never seen it on the two sides at once. It is also generally curable by treatment. Case No. IV. will illustrate these statements. Mr. P—— had, whilst suffering from syphilitic iritis, a sudden development of complete facial paralysis and deafness on one side. He recovered from the former, but remained ever afterwards absolutely deaf in the affected ear. A parallel occurrence took place in the case of Captain P——, and also in that of Mr. E. W——. It is not possible to be too prompt or too vigorous in the adoption of specific measures in any case of acquired syphilis in which the patient is threatened with deafness. More especially is this the case if the deafness comes on in the secondary stage; for it then often runs a rapid course, and if once it has become complete, I believe that recovery is very rare. Whenever a patient who is the subject of secondary syphilis consults us on account of any

affection of the organ of hearing, it is well to insist on his keeping his bed or room, and using mercury in such a manner as to rapidly bring about its full effect.

Probably this form of otitis is a close analogue of common syphilitic iritis. It appears to occur under very similar conditions; that is, in association with other secondary phenomena. It is certainly remarkable that it should be attended with so few subjective symptoms, and especially that noises, singing, and sense of stuffing in the ears should ever be so absolutely absent as they are in some instances.

In the tertiary stage of syphilis, when deafness occurs it is of far less importance. It rarely, I think, proceeds to extinction of the function, and is seldom permanent.

There is, of course, a fallacy which we must always be carefully on our guard against, in that the state of the throat in secondary syphilis may be the cause of defective hearing.

*CASE I.—Deafness in one Ear during the secondary stage of Syphilis—Diagnosis of Eustachian obstruction—Recovery.*

A young clergyman who was under my care on account of primary syphilis, having three large indurations in his prepuce, became suddenly deaf in his right ear. He had no singing in the ear, the bone-conduction on both sides was good. As there was difficulty in inflating the Eustachian tube and the membrana tympani was retracted, it seemed probable that his deafness was due to his throat. The specific treatment was continued, and a month later he wrote to me that the deafness had quite disappeared.

I have narrated the above case in order to illustrate the commonest cause of defects of hearing in syphilitic subjects. In the cases which follow, I shall take only those in which this source of fallacy was excluded.

*CASE II.—Partial deafness in both Ears in the secondary stage of Syphilis—Recovery under Mercury.*

A very threatening case of deafness in connection with secondary syphilis occurred in the person of a medical friend, whom I had treated for a chancre on his finger. Eight

months after the chancre, and at a time when he had suspended all treatment, he suddenly became deaf on both sides. The symptoms were those of nervous deafness, and he had no throat mischief. I urged him to keep his house and to push mercury. This he did, and in the course of a month had pretty much regained his hearing. At the end of the following year (November, 1880) I saw him again; he could then hear perfectly.

*CASE III.—Deafness and facial paralysis together in connection with Syphilis—Recovery from the paralysis, but permanence of the deafness.*

I saw Mr. E. W——, with Dr. B——, on August 29, 1879. It was believed that he had had primary syphilis in 1875, and for some time preceding our consultation Dr. B—— had been treating him on account of large nodes on his neck and head, one of which had suppurated. My chief interest in his case was in connection with almost absolute deafness in his right ear. This, he said, had occurred together with complete paralysis of the face on same side some years ago. I have not recorded the precise dates, but it must have been within a comparatively short time of his primary syphilis. He did not remember that he had ever suffered much from either headache or earache. Under treatment his facial paralysis had been completely removed, but he remained almost absolutely deaf in the affected ear.\*

\* Dr. Knapp has recorded the following facts in reference to "Deafness in Acquired Secondary Syphilis from Disease of Inner Ear" (p. 67). They illustrate what I have said as to the risk of permanence:—

Mrs. S. D——, 42, in May, 1870, began to have headache, nausea, and giddiness. Ice to head ordered.

July.—Pharyngitis and papular rash over whole body.

Dec. 23.—Suddenly she had severe headache, dizziness and nausea, but no vomiting; with intense tinnitus and rapid diminution of hearing. Was obliged to lie down; on attempting to get up she always fell, but not in any determinate direction. When lying down, the room seemed to roll from side to side, or to balance up and down, according as she lay on her side (the former) or on her back (the latter). In a week, almost absolutely deaf.

Jan. 12, 1871 (three weeks later).—Increase of headache and giddiness, with failure of sight, coloured vision, sparks, and wavering of surrounding objects;

The association of facial paralysis with deafness from syphilis was new to me when the case of Mr. P—— came under my observation. This case interested me exceedingly, for I could not but see at once how much help it gave us towards a correct understanding of the local cause of this form of deafness. It had previously been a matter of plausible conjecture that the nervous apparatus of the internal ear was the part implicated in almost all forms of syphilitic loss of hearing. Whether, however, the process was more analogous to optic neuritis, to retinitis, or to iritis, it was difficult to guess. No opportunities for post-mortem dissection had occurred to me, nor could they be expected. It seemed clear, however, when we saw the seventh nerve involved also, that the inflammation was probably one of fibrous tissues, and not primarily of nervous elements; that it was, in fact, the analogue of sclerotitis, iritis and choroiditis, rather than of retinitis or neuritis. The facial nerve could

these latter symptoms lasting only a few minutes, and recurring often during three days, but not afterwards.

*Jan. 18th.*—Well-marked double iritis with + tension. Syphilitic sore throat and papular rash still well pronounced. Much complaint made of noises in head. Mercury ordered. Rapid improvement in iritis, and as soon as fundus could be seen, vitreous found to be cloudy and neuro-retinitis present. No retinal hæmorrhages nor any exudation patches.

*After four weeks' treatment.*—Headache, rash, and sore throat almost well; giddiness less, hearing slightly improved. To have iodide of potassium and use electricity.

*Two months later.*—Iritis quite well, pupils movable; some neuro-retinal haze still remaining. Noises in ears continue, but are less distressing; still subject to dizziness, but can walk alone; hearing not better than last note. Health good, skin clear (April 22, 1871).

Knapp, *ibid.*, p. 72, quotes Gruber's remarks on deafness in syphilitic persons, which he translates thus:—

"I" (Gruber) "have had, up to the present time, the opportunity to examine four syphilitic soldiers, who had suddenly become deaf after having taken cold. They suffered from vertiginous attacks, from which they recovered, but remained deaf in spite of all treatment. One of these patients died from typhus fever shortly after his aural difficulty. On examination, considerable hyperæmia was discovered in the mucous membrane of the drum, and in the membranous labyrinth, which appeared much thickened. The liquid within the labyrinth was sanguinolent and abundant." Gruber asks, says Knapp, "whether this condition is perhaps to be thought an inflammation with hæmorrhagic exudation, to which syphilitic patients are predisposed? Further observations are needed." (From "*Arch. Ophth. and Otol.*" vol. ii. pt. 1, 1871.).

only become involved by pressure upon its trunk during its passage through the temporal bone. Hence the legitimate inference that the fibrous lining of its canals must be implicated in the inflammation.

The facial nerve enters the internal meatus with the auditory. At the bottom of the meatus they part company, and the facial pursues a winding direction in the Fallopian aqueduct and passing along the inner wall of the tympanum, finally arches downwards to the stylo-mastoid foramen, its aperture of exit. In one part of this course it lies between the cochlea and vestibule, and the whole of it is in such close connection with the internal and middle ear, that any inflammatory swelling might easily involve the fibrous lining of its canal, exercise injurious pressure on its trunk, and cause its paralysis. Nor is it easy to conceive of its implication in any other manner, for it is not in close association with the auditory nerve at any other part of its course.

We come, then, to the conclusion that the deafness which occurs in the secondary stage of syphilis is due to the inflammation of a sense-capsule, analogous to that which occurs in the eye, and of which iritis is the most conspicuous symptom. We know well that what we call syphilitic iritis is often an ophthalmitis implicating other structures than the iris; but it is one originating in cellular and fibrous structures, and not primarily or chiefly implicating the nervous elements of the organ. We may have a syphilitic retinitis without iritis, and in turn the latter without retinitis. The parallel probably holds good in the case of the ear, and the cases in which the trunk of the portio dura becomes compressed are those in which the fibrous structures are most severely implicated.

*CASE IV.—Deafness in the secondary stage of Syphilis, with paralysis of facial nerve—Recovery from the facial paralysis, with permanent deafness—Subsequent occurrence of other nerve symptoms.*

In this case the patient, Mr. P——, was a man of forty-five, in good health, for whom I had myself prescribed during the secondary stage of syphilis. He then had a copious eruption



and an acute attack of iritis in the right eye. The chancre occurred in March, and I prescribed mercury for the first time in June. He got rid of all symptoms. In September he was allowed (not by myself) to leave off mercury and took iodide only. For a fortnight he had left off all treatment, when, in the last week of the month, facial paralysis set in on the right side. I saw him on October 1st. He was then absolutely deaf in the right ear, and could not hear the watch when pressed over the ear, the forehead, or the mastoid. So insidiously had the deafness come on, that he had not himself found it out until his doctor discovered it. He had consulted Dr. P—— for the facial paralysis, and it was then found out that he was also quite deaf. The facial paralysis was not quite complete. He could just manage to shut his eye, but could not wrinkle his forehead; the side of the face remained expressionless during conversation, but on strong effort none of the muscles appeared to be absolutely paralysed. He thought that it was already beginning to improve. On inquiring particularly as to what his first symptoms had been, he replied, very definitely, "giddiness": "I reel in walking, and on one occasion I asked my brother if he had not noticed that I reeled, and he said that he had." At this time nothing drew his attention to his ear; he had no noises or uncomfortable sensations in it; and neither he nor his wife had noticed that he was losing hearing until, on consulting Dr. P——, it was ascertained that he was totally deaf in that ear. Soon after this was found out, he began to be conscious that the other ear was failing a little. On one or two occasions he had felt a little sick in connection with the giddiness, and once, on waking and turning over, he had vomited bile. At first there had been no pain in the head nor tenderness, but when I saw him, ten days after the commencement of the symptoms, he had a fixed pain in the top of his head, and there was tenderness, though without swelling, all over the mastoid region. The other ear had at this time decidedly failed, and he did not hear the watch until brought within eight inches. It is not without interest to note that the ear first affected was on the same side as the eye which had suffered first from iritis.

I saw this patient a second time two months later. During almost the whole of the interval he had been freely treated with mercury, and his gums had been for a long period kept sore. He had also taken latterly a good deal of iodide of potassium. The result had been that the right portio dura had almost wholly recovered, and that the symptoms which threatened the left ear had almost entirely disappeared. He remained, however, absolutely deaf in the right ear, and although he said that the hearing in the left was quite good, it was certainly somewhat defective. At first he could not hear the watch on his forehead, though after a while he thought that he did so, and he did not hear it in the air at any greater distance than about one foot. He could see almost perfectly with the right eye, but not so well with the left; the presence of vitreous opacities in both, and in much greater abundance in the left, probably explained this; there was no optic neuritis. A remarkable feature during the latter part of his illness had been a constant liability to severe neuralgic pains in his head. These had for several weeks almost entirely prevented his sleeping, and still did so to a large extent. He said that he rarely slept more than ten minutes at a time, unless under the influence of opium. He described the pain as "a biting pain," and said that it usually began in his forehead or eyes, and then passed to the occiput and top of the head. In connection with the pain he mentioned a symptom which I do not know that I ever heard described before, "an acutely burning sensation on the rim of the ears." He said that this was often intolerable, and that he could only relieve it by constant pressure. He had been confined to his bedroom during the whole treatment, and although he could walk and even move about quickly, he was very liable to giddiness in doing so. He usually kept his head wrapt in a shawl, for the slightest breath of air would, he said, bring on the neuralgia in his neck and head.

The prompt recovery of the portio dura whilst complete deafness remained renders it almost certain that the cause of both symptoms was, as we supposed, inflammation of the middle and internal ear.

On August 6, 1889, I saw Mr. P—— again. I made note

that he was still quite deaf in the right ear, but that his facial muscles had quite recovered. He had been at his office working hard for three months. His brain, he said, was perfectly clear. He looked well. At this date he had been taking specifics for more than a year. He said that he sometimes staggered in the street, and made people think that he was drunk; but he never had the slightest feeling of giddiness in the head. His sight was perfect in both, but he described symptoms of temporary failure of accommodation in the right eye. The [redacted] of the eyeballs were perfect.

I find from a note on October 12, 1889, that Mr. P—— had been quite well for some months, had been attending to his business and taking no medicine. During the preceding month, however, he had been suffering from severe neuralgia in the occiput and right side of head. He said that it affected the socket of his eye; and his reason for coming to me was that he had that morning found the sight of his right eye very dim. The dimness was all but gone when he reached my house, and he could just puzzle out No. 2. From his description and from the absence of any subjective symptoms, I inferred it had been a failure of accommodation.

On April 29, 1890, Mr. P—— was again under my care, having had an attack of what he called "paralysis of the tongue." It appeared that after having been at an evening party and got a good deal excited, he had awakened in the night in a condition which had much alarmed him. His expression was, "I could neither think, speak, nor write; I could not find words." This attack occurred on January 29th, and was only transitory. He had had no hemiplegia, but "felt numb and stupid." He was in bed on account of this attack for about a fortnight, and again took specifics. The loss of ability to speak was preceded by sneezing. He had gone to bed at five in the morning feeling quite well, and woke up in the morning sneezing, and feeling as if he were drunk. He thinks that he sneezed thirty or forty times in succession. At ten he got up and went downstairs, and just managed to say to his wife "paralysis." When he came to

me in April, these symptoms had passed off. He had just returned from a five weeks' stay at Hastings, and could speak well but slowly.

On July 1, 1890, I made the following notes. He feels nervous about himself; when he goes to sleep, it is with a feeling that he will die. Memory bad; he interpolates in speech, and in writing leaves out letters. He says what he does not mean. "My speech does not give the right interpretation of my thoughts." He clips his words. In posting his books he puts shillings for pounds, and pounds for shillings. He has had much anxiety in business. No headache. Pupils small, but act well. Sees  $\frac{2}{3}$ , but thinks his sight not acute. Reads No. 1, but cannot bring the book close. Accommodation evidently defective. "I go to bed with prayer, and wake with thanksgiving; it is an awful feeling of uncertainty." He can whistle, but with a little puffing of right cheek. Still absolutely deaf in the one ear. The otoscope did not reveal any changes in the membrana tympani.

I saw Mr. P—— again on Dec. 7, 1891, when he came to me on account of a symmetrical eruption of dusky erythematous blotches on his abdomen. He was in good health, but still quite deaf in the affected ear. He had for the most part got rid of the nervous symptoms described in the last note. I believe that he is now in good health.

CASE V.—*A second infection of Syphilis—Suppression treatment—An attack of fixed pain in region of ear in the eighth month—Complete paralysis of the facial nerve without deafness—Recovery.*

Mr. R——, aged 39, had been under my treatment for primary syphilis from January to August, when he was seized with very severe pain in the left side of his head. We called the pain "neuralgia," but it was of such severity and persistence that he alleged that for a week he scarcely slept. It was felt chiefly behind the left ear, but he described it as having begun in the ear. It was not attended by any degree of deafness. I administered quinine with mercury. The

neuralgia began at a time when, on account of ptyalism, he had done without mercury for a month. After the pain had persisted almost without intermission for a fortnight, his portio dura suddenly failed. At the same time the pain almost ceased. The facial paralysis was almost absolute. He could not move the cheek nor shut the eye. Still there was no deafness. Mercurial treatment was pushed to sharp ptyalism, and the paralysis in the course of a month had almost wholly disappeared. A month later he was threatened with a return of the neuralgia, but it passed off.

It must be mentioned that in this case the patient had been treated for syphilis by very competent surgeons nineteen years before the attack for which he consulted me. On the latter occasion he had no fewer than five well-indurated chancres, and they resisted mercurial treatment for a long time. He did not bear mercury well.

The cause of the facial paralysis and severe earache in this instance was probably syphilitic inflammation of fibrous structures in the middle ear. The internal ear escaped, and hence the absence of deafness. It was an example of syphilitic Bell's paralysis.

## CASES ILLUSTRATING DIAGNOSIS IN ORGANIC DISEASES OF THE KIDNEY.

THE cases which follow are, I think, all of some clinical value as illustrative of the symptoms which guide diagnosis in organic affections of the kidney. They also teach some practical lessons as regards treatment and prognosis.

CASE I.—*Stricture of Urethra—Painless Renal Tumour with pus and blood in urine—Fair health for a year—Increase of symptoms—Exploratory operation—Sudden death from Internal Strangulation of Bowel.*

The subject of this case was a gentleman of sixty years of age, who had enjoyed good health, but had long suffered from stricture of the urethra. The latter had, however, been well overcome when, about two years before his death, he consulted his family adviser on account of blood in his urine. In the course of an examination which followed, a tumour in the left side of the abdomen was discovered. The tumour had been absolutely painless, and was found quite unexpectedly. There was at this time pus in the urine, but the bleeding had quite ceased.

Not long after the discovery of the tumour I was asked to see the patient. I found a rounded swelling about as large as two fists in the left lumbar region, which projected forwards and lifted the colon on its front. The bowel could be easily felt and pushed from side to side on the rounded surface of the tumour. My diagnosis was that the tumour was probably a new growth.

I did not see anything of the patient for another year. During that long period he had resumed his duties as a librarian, and had suffered but little inconvenience from his

tumour. I had heard of him from time to time that he was doing well. At length, owing to an attack of pain, I was again asked to see him. I found him considerably thinner than he was a year before, and with a very considerable increase in the tumour. He had also for a week or two had much pain, and been confined to his bed. The tumour was now as large as a child's head, very tense, and presenting a doubtful sense of fluctuation. The urine was, and had for long been, free from both blood and pus. Thinking it very probable that the pelvis of the kidney was distended, I advised an exploration from the loin. This was done, and I opened a cyst which contained half a pint or more of a thin whey-like fluid. The removal of this did not much diminish the bulk of the tumour, and by further examination I became convinced that it consisted in the main of a soft solid, and that its removal was impracticable. A large tube was accordingly placed in the cyst which I had opened, and the operation was abandoned.

Everything went on well for nearly three weeks. The pain was relieved and the health improved, and although, of course, the tumour remained, we had some hope of getting our patient up again. Most unexpectedly one morning I heard that he was dead. No time was lost in seeking permission for an autopsy, and, this having been obtained, I made it in the afternoon of the following day. Before stating its revelations I may say that I was told that Mr. C—— had been quite well until the evening before his death. He was then, after taking some tea, suddenly seized with pain in the abdomen, and was sick. In an hour or two he passed into collapse, and his surgeon, who had been sent for, thought him dying. He rallied, however, and for a time seemed better. The sickness ceased, but the pain continued. In the morning he passed into collapse again and died. The whole duration of the symptoms had been only about twelve hours. As I had been aware in the exploration that I had passed instruments through the soft growth close up to the peritoneal investment, I naturally supposed that a cyst had given way into the abdomen. This, however, did not prove to have been the case.

On laying open the abdomen, which was done by turning the parietes down so as to fully expose the intestines *in situ*,

we were surprised to see several coils of small intestine of a very deep colour and tensely distended, whilst the rest of the bowels were quite pale and comparatively empty. Tracing the distended bowel backwards, I found directly that it passed towards the right iliac fossa, and that it there dipped through an aperture in the mesentery. The opening in the latter would have admitted three fingers, and upwards of three feet or more of bowel had gone through it. With a little trouble I drew the involved portion back, and we then had a clear view of the aperture. It had the appearance of having existed for some time, its edges being fairly well rounded, though not thickened. It was placed in a dense sheet of adhesions (or abnormally placed mesentery) by which the last part of the ileum was fixed to the brim of the pelvis. Probably this structure was a congenital peculiarity, for there were no adhesions elsewhere.

Several very remarkable features must be noticed in this case. First, the extremely rapid progress of the symptoms, the patient dying within twelve hours of their onset. No time was afforded for a consultation as to the propriety of an exploration; nor, if a consultation could have taken place, is it likely that a correct diagnosis would have been formed. Nothing would have seemed less probable than that a man who had been a month on his back in bed should suddenly have produced an internal strangulation of this kind. We may conjecture that the aperture had been there for years, or was perhaps congenital. What was the influence that induced the bowel under circumstances of such absolute quiet to pass through it, it is difficult to conjecture. The strangulation was not tight, and did not threaten the integrity of the gut. It was simply obstructive, and the collapse was no doubt due to the large portion of bowel involved. When first exposed, it looked as if half the contents of the abdomen were involved. The drawing back of the bowel was done with the greatest ease.

The autopsy allowed us an opportunity for examining the renal tumour. It consisted of a soft, sarcomatous growth which had everywhere replaced the kidney structure. There had also been much extravasation of blood into the tumour



substance. The removal of the kidney would have been quite impossible during life, and was only accomplished with the greatest difficulty after death. The adhesions on all sides were very strong and thick. Attention may be asked to the remarkably quiet and slow growth of the tumour, and to the fact that the patient had appeared to recover and had very fair health for a year.

*CASE II.—Malignant Cystic Tumour in connection with left kidney—Death after a year's illness.*

In June, 1884, I saw with Dr. King Kerr, of Leytonstone, a gentleman of about thirty years of age, who had been in bed upwards of six weeks in consequence of pain and swelling in the right hypochondrium. He had lost much flesh and looked ill. The tumour bulged so as to be visible to the eye, filling the space between the ribs and the crest of the ileum, but especially the upper part of it. It fluctuated distinctly; indeed, it had already been tapped and a large quantity of fluid drawn off. On the front and inner side of the tumour was a small movable mass, which I took to be the spleen. The tumour was fixed to the ribs, but less fixed below. It was not very tender, if gently manipulated. The patient had experienced a good deal of relief from the tapping. Dr. Kerr showed me a sketch of some cells which he had found in the fluid, most of which were round, twice or three times the size of blood cells, and containing distinct nucleoli and nuclei. Some were oat-shaped. The fluid drawn off was of a reddish-brown colour; no hæmorrhage whatever attended the tapping. Dr. Kerr told me that there was nothing abnormal in the urine, and that it never contained blood. We aspirated again on the occasion of my visit, and drew off from twelve to fifteen ounces of a brown fluid exactly like that obtained before. It did not coagulate. On examination of it at home, I found in it numerous cells exactly like those of which Dr. Kerr had shown me the drawings. I felt little doubt that the case was a malignant tumour springing from the kidney, with probably complete blocking up of the ureter.

A few days after my visit, Dr. Kerr wrote to me that he had

found in the urine some cells exactly like those obtained by the aspirator. He had on this third tapping removed two champagne bottles full of fluid.

The history in this case extended over a period of nearly a year, during which the patient had suffered with pain in the back, supposed to be due to disease of the spine. He had only been under Dr. Kerr's observation for a few weeks, having been previously under that of a homœopath.

The consultation to which the above notes refer took place on June 4, 1884. Our patient died from exhaustion about two months later. I had not seen him again, but Dr. Kerr informed me that he had been obliged subsequently to puncture the mass in several places in order to reduce the bulk of the tumour, since it appeared to consist of several distinct cysts. There was no post mortem.

It will be noticed that this case occurred nearly ten years ago, when there was less experience as regards extirpation of the kidney than we now possess.

*CASE III.—Tumour of Kidney recognised during life—Death two years later—Autopsy—Cystic Kidney on both sides.*

Mr. T. G——, aged 46, was brought to me by Dr. Lyle, of Dunmow. The history was that one night, after making water, he experienced a very sharp pain in his left loin. It kept him awake the rest of the night. Three weeks after this attack of pain he had hæmaturia, which continued more or less for four days, but was wholly unattended by pain. The bleeding led to Dr. Lyle being consulted, and to an examination of the abdomen, when a very distinct rounded swelling was discovered in the left loin. It was on account of this that he was brought to me. I saw him on the first of January, 1888. On examination I found a hard, rounded mass in the left side of the abdomen, easily felt by the hand, in front, and filling the space between the ribs and iliac crest. It became more evident when the man turned on his right side so as to allow the intestines to fall away. By one hand placed over the loin and the other over the front of the tumour it could be easily passed backwards and forwards. On its front surface

could sometimes be felt a rounded finger-like body, which passed vertically down it and which I took to be the empty colon. Thus the diagnosis that the tumour was the kidney, or a tumour connected with it, seemed clear. It was absolutely painless, and the man went about his occupation just as usual, averring that he had no discomfort of any kind. His urine was now free from blood. He had never passed a stone, but had once experienced a cutting pain in micturating. We agreed that it was a case to watch and in which for the present all operative measures were better avoided. As the result proved, this was a wise decision. The kidney tumour remained much of the same size and occasioned no inconvenience. The patient lived on in the enjoyment of fair health for between two and three years. At the end of this time he had a large carbuncle, and although the latter had nearly healed, he passed into a condition of great debility and died. He was perfectly conscious to the last, and had none of the ordinary symptoms of uræmic poisoning. Dr. Lyle procured a post-mortem examination, and was good enough to inform me that he found the kidney in a condition of advanced cystic disease. Its fellow organ was in a similar state, and almost as much enlarged. They contained, Dr. Lyle states, hundreds of cysts, by which the normal kidney structure was wholly replaced. No calculus or other cause of obstruction of the ureters was found.

It will be seen that an interval of more than two years elapsed between the date of our examination and the man's death. It was no doubt during this period that the enlargement of the right kidney occurred. We had made a careful examination of the abdomen, and could not well have overlooked it had there been any enlargement at the time of our consultation.

We have but little knowledge as to the causes of the cystic kidney, the rate of its progress, or the symptoms which attend it. It is a condition which is usually discovered unexpectedly on the post-mortem table. The case now recorded becomes, therefore, of some interest as giving support to the belief that the condition may commence in one kidney and after a time invade the other, and that its progress may

be tolerably rapid. The attack of pain and the hæmaturia remain, of course, unexplained, and it is perhaps not improbable that they were due, as was supposed at the time, to the presence of some calculous matter.

Cases such as the above offer a warning against hasty operations for tumours of the kidney. It is quite possible that an organ might be extirpated which did not in itself involve other than negative risk to life, and the functional activity of which was not wholly ended.

That a man should continue in apparently good health with very advanced cystic disorganisation of both kidneys is a fact which need not appear incredible, since not a few similar cases are on record. I well remember such a case, a man who was admitted into the London Hospital (March, 1870) with a compound fracture of his leg. The injury had been caused on board ship, and he had worked as an ordinary seaman up to the day of its occurrence. Neither before the accident nor whilst in the hospital had he ever mentioned any renal symptoms.

The following are some notes of the case taken at the time.

*CASE IV.—Compound Fracture of the Leg—Death in the sixth week—Cystic Disease of the Kidneys in very advanced stage.*

Alexander King, æt. 41, an able seaman, was admitted into the London Hospital, March 16, 1870. Five weeks previously he had been injured severely by a wave breaking over him while steering his vessel. He sustained a compound fracture of the left leg. Splints were applied by the captain of the vessel, and a pad placed over the wound. Owing to severe weather they were detained at sea, on short provisions, till the time of his admission. The wound was only dressed once. On admission it was found that the bones had not united, the wound was not of large size, and the leg could be placed in a fairly straight position. The tibia, however, was bare and white for some two inches above and below the wound. It was a question as to whether amputation should not be performed at once; but it was determined to wait a little while and see whether he would improve in strength. His temperature was 99°0', and his pulse 120 and feeble. His tongue was clean, but tremulous, and though he spoke with energy he did not seem in a favourable condition for any operation to be performed. In the evening his temperature was 102°7', his pulse 148, and his respirations 18. He had had no rigor. During the next few days there was some improvement in the condition

of the wound. The soft parts were becoming adherent to the bone, and the wound contracting. It seemed as if it were quite possible for the bone to exfoliate. His temperature, however, remained high. On the 17th it was  $100.4^{\circ}$ . On the 18th, morning,  $99.7^{\circ}$ , evening,  $101.8^{\circ}$ . 19th, evening,  $103.6^{\circ}$ . 20th, evening,  $102.4^{\circ}$ . 21st, morning,  $99.0^{\circ}$ . 23rd, evening,  $101.3^{\circ}$ . 27th,  $101^{\circ}$ . At this date he became delirious; every now and then he would begin to talk very incoherently and loudly about his voyage, his accident, &c. He did not actually attempt to get out of bed, but threatened to do so. His skin was sweating, and his tongue tremulous, but clean. He knew those of us whom he had seen take notice of him, and called us by name. On the 28th, in the evening, while much the same, chloral was given him, with the effect of quieting him at once, but only for a time. The doses were repeated, and his temperature sank from  $100.4^{\circ}$  to  $98.4^{\circ}$ . As he seemed weaker on the 29th, however, though quiet, it was considered advisable not to continue the chloral. The delirium became of a muttering kind, his temperature rose from  $98.4^{\circ}$  while under the influence of the chloral to  $101^{\circ}$ , then  $104^{\circ}$ . Then  $104.2^{\circ}$  during the 29th, 30th, and 31st. On the 1st April he was worse, and subsequently he gradually passed into a comatose condition, and so died.

At the post-mortem examination, conducted by Dr. Hughlings Jackson (then Pathologist to the hospital), no changes of note were found in any of the viscera except in the kidneys. These were in a condition of the most advanced cystic degeneration.\* The two kidneys looked exactly alike; the weight of one only was tested, it was two pounds all but an ounce. The ureters were of normal size, but contained a purulent-looking fluid. The bladder was quite healthy, and contained a quantity of moderately clear urine floating over a thicker purulent portion. On testing, a large quantity of albumen was found. The fluid in the cysts was also highly albuminous. The urethra was free from obstruction. The liver and spleen contained no cysts.

*CASE V.—Periods of Comatose Sleep in a Servant-girl—Supposed Hysteria—Death in Coma—Extreme disorganisation of both Kidneys.*

A very instructive case in proof that the ordinary symptoms of kidney disease may be wholly absent in states of very advanced disorganisation came under my observation at an early period of my professional career. In 1850, when I was House Surgeon to the York County Hospital, a maid-servant was admitted for symptoms which were supposed, by a very sagacious physician, to be merely hysterical. She had kept

\* An excellent wax model of the kidney is preserved in the museum of the London Hospital.

her place and done her ordinary work up to the time of her admission. Her most remarkable symptom was the liability to pass into a state of coma, and to remain for several hours in a condition from which she could not be roused, and then suddenly to wake up and walk about the ward. These attacks were supposed to be feigned. At length, in one of them she died. At the post-mortem the kidneys were found extremely atrophied; all trace of cortical structure had disappeared, and one of them weighed only a few drachms. They consisted of hard white fibrous structure, and neither was as large as a walnut. This patient had never had any form of dropsy, and had been considered to enjoy fair health until about ten days before her death.

CASE VI.—*Hydronephrosis on the right side in a Boy—Partial removal by Lumbar operation—Recovery with a Fistula.*

About six years ago Dr. Dean, then of the Gray's Inn Road, brought to me a boy of fourteen who had a large tumour in his abdomen, apparently developed from his right kidney. Dr. Dean had already very carefully diagnosed the case, and had repeatedly tapped the tumour. It had become necessary to aspirate twice a week on account of the rapidity with which re-distension occurred, and the boy, although still able to go about, was losing flesh and strength. The tumour filled the right lumbar region and the right half of the abdomen quite up to the middle line in front and passed below the anterior iliac spine. There had never been anything amiss with the urine, the boy had never passed gravel, and no precise date could be given for the commencement of the renal disease. The fluid which Dr. Dean had drawn off was thin and opalescent, and had no definitely urinous odour. After each tapping, the tumour for a day or two disappeared. It was on account of the increasingly frequent necessity for tapping, and the seeming desirability of some more radical operation, that Dr. Dean brought the patient to me. I at once agreed with him that it was clearly desirable to expose the kidney, and, if found practicable, to remove it. The exploration was made a week or two later, at the boy's home, by a free incision in

the lumbar region. The kidney was laid bare and opened. About a couple of pints of fluid having been removed, I then found that the cavity had thin leathery walls which it was very difficult to detach. On the most careful exploration of the interior of the cavity I could detect no calculus. Having detached the dilated kidney posteriorly, I cut away as much of it as I dared, the portions removed being of about the consistence of stout shoe leather. I made a long and patient attempt to peel it away anteriorly, but fearing to cut into the peritoneum, I did not venture to use either knife or scissors, and I quite failed to detach the anterior two-thirds of the cyst wall. Having removed as much as I thought it safe to take, we inserted a large drainage tube and closed the angles of the wound.

After the operation the boy, under Dr. Dean's assiduous care, progressed better than we could have expected. He was ill for a time, but never alarmingly so. What remained of the renal cyst continued to secrete for some months very continuously, and it was of course carefully syringed out. At length it contracted to a fistula, and at this stage the boy wore a canula and plug, and his mother was accustomed to wash out by the canula every morning. On one occasion, about a year after the operation, we had an alarm that the canula had slipped into the wound: it had at any rate been lost. This gave us an opportunity for re-examining the cyst. I enlarged the fistula and passed my finger freely in, with the result of finding that the cyst was very much contracted, but with an entirely negative result as regards finding the missing tube. There was a funnel-shaped cavity in the direction of what I supposed was the ureter, and into this I passed a probe, but could discover no foreign body. We continued the same treatment as before, and as no symptoms of irritation were ever developed, we assumed, in the end, that the tube had been lost externally and had never got into the cyst. It was a small one, made of vulcanite.

The state of the boy (October, 1888), two and a half years after the operation, was as follows: He was well grown and in strong health. He was now sixteen years of age, and in regular employment in an office. There still remained a

sinus in his loin, in which a small plug was worn. There was no evidence of any tumour in the abdomen, but a thickened mass the size of a small apple could be indistinctly felt in the loin. The quantity of discharge was not more than a few teaspoonfuls a day. He had to wear a small pad, but it did not materially interfere with his comfort.

Six years have now elapsed since I last saw this lad. He has returned home to Scotland and is, I am assured, in very good health.

The pathology of this case remains somewhat obscure, but it is highly probable that the cystic dilatation of the kidney was due to mechanical obstruction of the ureter; and by far the most probable cause of such obstruction is a calculus. It is possible that the calculus has become permanently encysted in the track of the ureter, and has occluded it; although in making this suggestion I am not sure that I could support it by the production of a parallel pathological preparation. There are many, however, which show long continued impaction of calculi, though without absolute occlusion. It is scarcely possible to imagine that anything short of almost absolute occlusion could have produced such extreme distension of kidney. On the theory of mechanical occlusion by a calculus, which had probably remained for some time in the pelvis of the kidney, it is somewhat difficult to explain the entire absence of pus and blood from the urine. I must just add that in the portions of the cyst wall which we removed, little or nothing could be discovered which represented kidney structure. The interior of the cavity was, however, partially divided by projecting ridges. The appended woodcut is from a preparation in the museum of the Veterinary College, which shows the kidneys and bladder of a dog which died from calculus. Calculi were found in his bladder. It will be seen that one kidney, the one in which no doubt the calculi originated, is completely destroyed and converted into a cyst, while the other remains perfectly healthy. This is a condition which I conjecture existed in my patient. What is known as surgical kidney very commonly affects both kidneys. We must remember, however, that the ordinary causes of surgical kidney are such



as to affect both organs, being present either in the urethra or the bladder itself. In such positions, of course it would throw back the secretion equally on both organs. If, how-



ever, a ureter were obstructed, we may easily get dilation of one kidney only, and this is my hypothesis in the present case, since it is obvious that the remaining organ is sound.

## A CASE OF PARAPLEGIA.

THE following notes concern an important case which was in its commencement diagnosed and treated as hysteria. In the course of a year or two from the beginning, it became tolerably evident that there was organic disease. Even, however, after the patient was confined to her bed and appeared to be paralysed and helpless, some doubts were entertained, for she was a young lady at the hysterical age, and she preserved a perfectly healthy appearance, suffered no pain, and seemed quite contented with her position as an invalid. I cannot say that I ever had myself any doubt as to the organic nature of her malady, and this opinion was fully shared by Dr. Hughlings Jackson, who was good enough, at my request, to examine the patient within a week or two of my having first seen her. The patient lived on for several years after this, quite paralysed as regards her lower extremities, and with a degree of implication of the upper ones also, which varied a little at different times. Finally, after about an eight years' illness, death took place. The case is tolerably complete, with the exception that there was no autopsy. Little doubt can, however, be felt that it was a case in which some slow process of disorganisation had taken place in the spinal cord itself.

It may be convenient to commence the narrative by the notes which were taken at the time Dr. Jackson saw the patient with me. I prefix, however, as likely to save the reader's trouble, a Scheme of the case arranged on the "space-for-time" method.

AGE.	DATE.	DETAILS.
16	1876	Suffered at times in the summer from severe aching pain between the shoulders and in one shoulder. At Christmas had a spinal illness, "inflammation of spine."
17	1877	Was again in fair health. July went to Ireland. She was able to walk, but not to run. Afraid of falling. One leg used to drag. Whilst in Ireland her limbs failed, and she came home partially paralysed. Hysteria was now the diagnosis.
18	1878	Seen on February 17th by Dr. Jackson and self. Unable to use any limbs excepting left arm, and that only a little. Reflex spasms easily excited. No spinal tenderness. All muscles flabby and wasted, deltoids especially. Constipation and retention of urine. Sphincters weak. Sensation nowhere wholly lost.
19	1879	March. After a year's total rest in bed no great improvement. Left arm better, and sphincters better. In good general health. Reflex spasms frequent, and often very painful.
20	1880	November 13th. The left hand and arm so much better that she can write with it. Second consultation with Dr. Jackson. Health excellent. Sphincters better. Spasms of limbs less frequent and less painful. She keeps her bed absolutely. Cannot use her lower extremities.
21	1881	Much the same, but able to be out daily in an invalid chair and to go to church. Fingers of right hand closed in the palm. Able to use left hand for many things.
22	1882	The same symptoms. Quite free from pain. Cheerful and happy. A great reader.
23	1883	At her own strong wish was taken to a warm seaside resort in November. Whilst there she failed in strength, and it became necessary to bring her home.
24	1884	In the beginning of March she experienced fatigue after a drive. Subsequently there was much brain excitement and rapid failure of strength. She died March 13th. There was no autopsy.

## NOTES TAKEN IN FEBRUARY, 1878.

Dr. Hughlings Jackson met me in consultation on February 17, 1878. We found that all the muscles responded to faradization equally and definitely, though somewhat feebly. Even the deltoids, which were those most visibly wasted, could be felt to contract somewhat. The comparative stiffness of the left shoulder appeared to be due to rigidity of the great pectoral muscle. This muscle was slightly rigid on the left side, but much more so on the right. It is to be observed that the left upper extremity was less involved in the paraplegia than the other.

I examined her spine very carefully with a view to determine whether or not there was any disease of the bones. No thickening nor any irregularity could be detected, nor was there the slightest tenderness. A blow on the top of the head, jarring the spine, gave her no pain.

Inability to relax the muscles seemed to be a very characteristic feature. It was shown not only in her inability to allow the urine to escape even when the bladder was uncomfortably full, but in the fixation of her limbs whenever they had been placed in certain positions. If her feet were touched, a condition of reflex spasm was produced, and one foot was pointed over the other, or the toes pointed downwards, and in this position the limb remained, resisting considerable force to straighten it. It was exceedingly difficult in handling a limb thus involved in slight muscular spasm to get rid of the impression that the patient was wilfully resisting. There was also another peculiarity, that the joints had lost the normal smoothness of action, and moved like those of a wooden doll, in which, after overcoming some hitch, the bones would suddenly slip, and then become hitched or locked again. I noticed this tendency of the limbs to pass into a condition of slight rigidity, especially in the upper extremities. The arm, when put quite straight at the elbow, became slightly stiff, and I could not bend the elbow by lifting the hand, but had to take hold of the upper arm, when it gave way quite suddenly, just like a wooden limb with a hinge.

Miss W— could do nothing to help herself in sitting up. When held in the sitting posture in bed her head bent forwards, but she could raise it, and had good use of all the muscles of her head and neck, including the trapezius. It gave her no pain to bend the neck into any position. There was a clear history that in the early stages of her complaint she had had a good deal of pain between her shoulders and in the lower part of the neck. This pain had been increased by exercise, and had sometimes disturbed her rest. She had, however, never required treatment for it. For the last six months this pain has been almost wholly absent. I forgot to examine as to the state of thoracic respiration.

There had never been any tendency to bed-sore. This is to be explained, in part at least, by the fact that, although the power of motion is lost, that of sensation is not so, and she is thus enabled to avail herself of the help of her nurses whenever pressure causes pain. Her custom at home has been to spend the greater part of the day on the couch, but to be taken out of doors frequently in a bath chair and in a reclining position.

Great difficulty has been encountered in keeping the bowels open, and frequent changes have had to be made in the aperients used. A sort of constipation of the bladder has also been very troublesome. She has but very rarely had incontinence of urine, but it is a common thing for the urine to be retained for twenty-four hours, and at the end of that time for her to experience great discomfort and be for half an hour or more unable to empty it. During this time her nurses are accustomed to rub and press the bladder, and often painful contractions of the lower limb

are induced. At length the sphincters will yield, and a full flow of urine occur. These attacks are only occasional. As a rule the bladder will empty itself when moderately distended. The catheter had never been used.

Dr. Jackson and I agreed in an unqualified opinion that the case was not one of hysteria, being much helped to this opinion by the state of general muscular emaciation which existed. Miss W— was a florid, blooming girl, quite free from expression of suffering, and she had not lost her subcutaneous fat. Her muscles, however, were everywhere in very poor condition, and notably her deltoids had so much disappeared that they could scarcely be felt. We had also the facts that the upper extremities as well as the lower were involved, and not quite symmetrically, that sensation was not asserted to be wholly lost, and that she did not complain of the slightest spinal tenderness—that is, there was no feigned hyperæsthesia. The condition of the limbs as regards reflex contractions and rigidity, and the history of the bladder retention, were also, as it seemed to us, quite genuine, and as if in connection with organic disease.

We were told afterwards that, prior to her complete failure, and whilst able to walk about, Miss W— had been brought to London, and had seen an eminent surgeon. At this time she had merely weakness of the limbs and dragging of one foot, and the opinion given was that it was hysteria, and change of scene, &c., had been urged.

Dr. Jackson advised that she should not be allowed to go out or to be put on the couch, but kept constantly in bed, and to take iodide of potassium and have the spine cauterised. I was myself much inclined to suspect that some cause of pressure upon the cord existed in the lowest part of the cervical region. The symptoms were exactly like what I have several times seen in cases of angular curvature, and we had here the history of pain in this one part as the first and for some time the only symptom. Opposed to this opinion was the fact that no tenderness, or thickening, or distortion could be detected.

If we reject the theory of pressure from without, and also the hypothesis of hysteria, we have to suppose some structural disease of the cord itself, located probably in the cervical region. We both agreed in thinking recovery not improbable, and that without any very special treatment. Of the pathological anatomy of any form of recoverable organic disease of the spinal cord we have, I suspect, but little definite knowledge.

The above notes were, as above stated, written out after a consultation on February 17, 1878.

In June of the same year I had a letter from her father, which reported a slight gain in power in the left upper extremity. She suffered increasingly from involuntary contractions.

of the lower extremities. She had had one knee swollen (without pain). The mercurial which we had prescribed had been discontinued because ptyalism had been produced. After a night disturbed by spasm her back would ache, but not otherwise.

The following letter from her medical attendant gives particulars as to her state on April 6, 1879 :—

“ I very carefully examined her, which I had not done for a long time, her condition being much the same. I found the pupils alike, and dilated well when shaded. I think the sphincter ani acts, for her mother introduced her finger, and found it contracted, and it appears there has been no difficulty in retaining the fœces—at least there has been no involuntary escape. There is no incontinence of urine. At times she does not micturate for many hours—as long as eighteen hours—but still not attended with difficulty, nor has she ever required the use of the catheter. I percussed her spinal column, and caused a good deal of pressure in the cervical vertebrae ; it gave her no pain or discomfort. There is undoubted wasting of the right deltoid, the right arm being rigid. On attracting her attention from herself, I had no difficulty in bending the elbow, wrist, and shoulder joints ; when asking her questions as to the arm I could not do so. She is able to raise her head off the pillow, also the right arm to her head, but cannot grip the hand. Her general health is good, and I don't, as far as appearance goes, know a healthier-looking face in this parish. She is very placid, and evidently enjoys, from her own account, her unfortunate existence. As to the nature of the case, I am at a loss to understand it. She came under my care two years ago last Christmas. She was then walking lame. On examining her spine, there was slight pain and tenderness in the lower cervical region. I considered there was some mischief within, kept her in bed for a month, applied locally counter irritation, gave her the iodide, thinking, should there be any effusion causing pressure on the cord, it would remove it. At the end of this month, pain and tenderness had ceased.”

In November, 1880 (nearly three years after my first consultation), I again saw Miss W—. She had improved considerably in ability to use her left hand and arm, and could just manage to write. The right upper extremity remained useless, with the exception that she could lift it a little from her side. Sensation had improved in the legs and feet. She could generally tell where she was touched on any part of foot or leg. The tendency to draw up the legs was much less than formerly, but still occurred some-

what. The legs still had a tendency to cross each other and to be held stiffly. There was often difficulty in parting the knees. The following notes had been supplied by her father, and narrate the symptoms which had been observed at her home :—

"November, 1880. She has improved considerably in ability to use her *left* hand and arm. She can now hold a pen feebly, but with sufficient firmness to enable her to write, with painstaking, and even to accomplish little pen-and-ink etchings. She can now also feed herself (her food being cut up for her). The *right* hand and arm remain useless, but power of movement seems returning, as she is now able to move the arm from the shoulder, about a foot from her side (not more); but the fingers of the right hand are still powerless, and the arm stiff at the elbow joint, and somewhat distorted. The legs are still entirely (?) beyond her control, but the spasmodic movements which used to be so distressing are neither so violent nor so frequent, nor does she suffer as much pain in them as she used. It should be noticed, however, that the legs, although not so painful, are perhaps as stiff, and show a strong tendency to *cross*. Pain in the back is seldom felt now; if felt, it is generally traceable to some temporary cause. The *neck* is much stronger, and pain rarely felt in it. There is much more control over the natural functions, although this control is by no means re-established. Her flesh keeps up well, and the limbs are all stouter than they were at the last report. Spirits equable and bright, brain active. Menstruation very regular. Any advance made or power regained has been in the *hot* weather, but she does not lose in the winter anything gained in summer, though progress seems then at a standstill. Still, in cold weather the hand (*left* one) does not seem so capable (temporarily) as during warm weather. Her nights are much less disturbed. Generally she has to call her nurse two or three times in the course of the night. This is when she gets into uncomfortable positions through the involuntary springing of her legs or curving of her body, she being powerless to move herself back into a comfortable position. Her sleep is good, her appetite also good."

It will be seen that at this time there were no indications that the disease was aggressive. Nor did it seem to threaten life. The patient in her paralysed condition had yet borne a long journey to town without unusual fatigue. She still bore the appearance of good health. There did not appear to be any reason why her life should not be indefinitely protracted.

I did not see Miss W—— again, nor did I receive from her friends any detailed reports. Her case was regarded as

hopeless, and no further measures of treatment were resorted to. In 1884 I heard that she had died, and the following particulars of her subsequent progress and of her last illness were supplied at my request:—

During the three years 1881, 1882, and 1883 she was, on the whole, rather less disabled than formerly. Her lower extremities and her right upper one remained quite paralysed, but they were less liable to spasm and not contracted. She was frequently taken out in a bath-chair and would go to church, and even occasionally take a drive. She could use her left upper extremity to feed herself. She was fond of music and of reading, saw her friends, and enjoyed her life. In November of 1883 she was taken, at her own request, to a warm seaside place. Whilst there she flagged, but after her return home was still able to go out. Her final illness was only of ten days' duration, and was attended by cerebral excitement and tendency to coma. In this state she died quietly on March 17th.

In thinking over this case I have half regretted that no exploratory operation was done. Although most of the symptoms pointed to myelitis, yet they by no means made this diagnosis a certainty, and there remained a possibility that they might be caused by pressure. In the early stages of the case we discussed this repeatedly, and put the suggestion of operation aside as likely to be attended by more risk than probability of benefit. We had also at that time much hope of recovery. It might, however, in the later stages, have been well worth while to make an exploration.



## ILLUSTRATIONS OF HEMIPLEGIA IN SYPHILIS.

I HAVE written out the notes of a great many cases in which attacks of hemiplegia occurred to patients who had suffered from syphilis. This form of hemiplegia is, I suppose, in nine cases out of ten, perhaps in a yet larger proportion, caused by arterial disease. Very rarely indeed is it induced by a gumma, and it is not commonly attended by hæmorrhage. Most cases recover, and but seldom does any relapse occur. My notes of several cases extend over many years, and prove that such patients may recover perfectly and retain good health. The opportunity of obtaining a post-mortem has but very rarely occurred to me. Although for this reason my cases are all incomplete, yet I think that some of them may prove of interest to my readers, and may afford hints as to diagnosis and treatment. In some I have been especially careful to give the details as to the preceding symptoms and mode of attack, believing that much help in diagnosis may be obtained from such records. Cerebral seizures resulting from arterial disease differ in a general way both from those caused by hæmorrhage and those due to embolism, in that they are not absolutely sudden and unexpected. Very often, indeed usually, there has occurred previously discomfort in the head and possibly some transitory numbness or tingling in the limbs affected. The artery, or arteries, affected have been undergoing gradual occlusion, which finally becomes complete. Thus the portion of brain involved has been deprived of its blood rather gradually, and there has been time allowed for the occurrence of premonitory symptoms. This circumstance has been a noteworthy feature in most of the narratives before me, though by no means in all. In some cases, especially those occurring in senile patients and after a long interval

since the original syphilis, there may be some uncertainty as to whether the cerebral lesion was really due to the specific disease. I do not think, however, that there are many in my list respecting which much doubt could be entertained. I shall do my best to make each case explain itself, and so without further preface will proceed to their narration.

The first which I will give is one of the first which attracted my attention to this form of hemiplegia. It occurred more than twenty-five years ago, and at a time when cerebral syphilis had received much less attention than it has since had. I give it as written out soon after the patient's death.

CASE I.—*Tertiary Syphilis—Cerebral attack, with defect of sight and partial Hemiplegia—Rapid recovery.*

Mrs. G——, a widow of about forty, was under my treatment in 1861 for a very large and deep ulcer in one leg, which I had no doubt was of syphilitic origin. There were circumstances which made me unwilling to make inquiries. I treated her by full doses of iodide of potassium, and the sore healed. Six months later she came to me with a deep ulcer in the tongue, again clearly tertiary, and again cured satisfactorily by the iodide.

One Sunday in December, 1868, I received a message that Mrs. G—— had had a fit, and that she was very desirous that I should see her. I found that since her leg and tongue had got well she had been in excellent health until the present attack, and had had no relapse of syphilitic symptoms. On the Saturday night she went to bed feeling quite well. She awoke in the morning with a strange feeling in the head, and, looking at the window, supposed at first that snow had fallen, as everything seemed white. Her right arm and leg felt "curious" and a little numb. When she stood up she felt as if she must fall over to the right side. When I saw her in the afternoon she could only read capitals, although on the previous evening she had read the newspaper easily. I could detect no loss of sensation, nor was her face drawn. She was up, and could stand and

walk, but the right limbs were very weak, and she was aphasic. I again prescribed the iodide.

On Wednesday she was much better, and could again read perfectly. I now used the ophthalmoscope, and found the fundus of the eye in a normal state. She still complained of the weakness of her right limbs. Her memory and all other faculties seemed perfect.

Mrs. G—— recovered perfectly from the attack above described. Two years later I was again consulted, and found her confined to bed with rapidly spreading cancer of the vagina. It had already perforated the bladder, and she died a few months later. I had no opportunity for a post-mortem.

My next case is one which I saw not long after the preceding.

CASE II.—*Hemiplegia (right) in the third year after Syphilis—  
Recovery, with contractions—Good health twenty years later.*

A gentleman of about forty-three, who had suffered from syphilis some years before, became paralysed in his right limbs. The attack was preceded by several occurrences of tingling and numbness in the arm. Especially in the morning of the seizure he had repeatedly experienced inability to use the hand for some minutes at a time. The syphilis had occurred in 1871, and the attack of paralysis was in October, 1873. Within a year of the primary disease, however, he had been very ill with cerebral symptoms, and for a time comatose and not expected to recover. He was at that stage seen by Mr. Hilton, Dr. Hughlings Jackson, and Sir William Jenner, all of whom prescribed mercury. Under specific treatment, long continued, he recovered, but still remained liable to giddiness. In August, 1873, he went to Scotland in tolerably good health, but still taking bichloride. In October of the same year "the seizure" occurred. He lost the use of the right arm and leg, and became aphasic. He never wholly lost consciousness. I did not see him till four months after this attack. He had been continuously taking specifics, and we continued them.

The subject of this case is still living, twenty-one years after the seizure. The hemiplegia has been followed by contractures, and his limbs are to a considerable extent disabled. Nor has he ever recovered perfect speech. He can write well with his left hand, and can walk a mile or two at a time. He has during the twenty years enjoyed fair health, but about six years ago he had several falls from giddiness, the attacks being possibly of an epileptiform nature. No symptoms of syphilis have developed since the seizure, and we appear to have a good example of permanent cure. His brain functions have been recovered so far as the local lesion left it possible. The case is, for purposes of prognosis, a very valuable one. Next to it I may place the case of a

*Partial Hemiplegia in Syphilis.*

CASE III.—*Syphilis—Early but imperfect treatment—Secondary symptoms—Reminders—Node on tibia and hemicrania in fourth year—Facial and brachial hemiplegia in fifth year.*

DATE.	AGE.	DETAILS.
1889	22 (1)	A chancre. Early treatment, but it did not prevent sore throat, &c., and some eruption. Never pytalism at any time.
1890	23 (2)	Treatment till August. Went to Australia. Had dysentery. Palmar psoriasis showed itself.
1891	24 (3)	In England in good health. Taking medicine off and on.
1892	25 (4)	No medicine. Node on tibia. Headaches began; pain over right eye. "Nearly drove me silly."
1893	26 (5)	In America. Had headache, and took iodide for six months (gr. x). A node on tibia. A seizure in December.
1894	27 (6)	Seen by me on January 12th. Still imperfect facial paralysis and inability to write. It was a fortnight since the attack.

In the above case the patient had never from the first been long free from symptoms. He described the pain of the hemicrania in the fifth year as having been exceedingly severe. The attack of incomplete hemiplegia was not preceded by any warning symptoms. It was at first thought that he had "Bell's paralysis," as his mouth was awry, but soon afterwards it was found that he could not write. The seizure might have occurred during sleep, for at breakfast his articulation was noticed to be

defective. After breakfast he went to a shop, and found unexpectedly that he could not sign a cheque. The leg was not affected in the least. He never lost the power of grasping with the right hand, but simply could not write. He had partial facial paralysis, and could not whistle. He could always frown and shut both eyes. His mouth constantly deviated to the left whilst he was talking to me. No defect of sensation had been noticed in face or limbs. He was not giddy or ill at the time of seizure.

There was no increase of symptoms after the seizure, but rather gradual improvement. It was a fortnight after the attack when he came to me, and he still had the incomplete facial paralysis, the inability to write, and a certain liability to choke in swallowing. His fifth nerve-muscles were perfect. He had not the least headache, and no other symptoms of syphilis. He had been taking iodides, and I advised him to push mercury to salivation.

CASE IV.—*Syphilis—Prolonged treatment and recovery—Good health—Syphilitic Lupus and Periostitis in the tenth year—Left hemiplegia in thirtieth year—Subsequent liability to spasm and pain in the lower limb.*

DATE.	AGE.	DETAILS.
1860	23	Had syphilis; was treated with mercury and iodide.
1861	24	Long under treatment; salivated slightly.
1862	25	Well.
1863	26	Well.
1864	27	He married.
1865	28	<div style="display: flex; align-items: center;"> <div style="font-size: 3em; margin-right: 10px;">}</div> <div>           Not a day's illness. Two sons born about this period are living now and quite healthy.            He lost only one of his children, the youngest (from phthisis).         </div> </div>
1866	29	
1867	30	
1868	31	
1869	32	Lost his wife, and became much depressed.
1870	33	
1871	34	Had syphilitic lupus on scalp, and a gumma in tongue.
1872	35	Took iodides and mercury.
1873	36	<div style="display: flex; align-items: center;"> <div style="font-size: 3em; margin-right: 10px;">}</div> <div>           No serious illness; leading an active life. Occasionally suffering from local pains, and accustomed to resort to iodide of potassium for their relief.             An attack of "arthritic iritis" in right eye.         </div> </div>
1874	37	
1875	38	
1876	39	
1877	40	
1878	41	
1879	42	
1880	43	
1881	44	
1882	45	
1883	46	
1884	47	
1885	48	<div style="display: flex; align-items: center;"> <div style="font-size: 3em; margin-right: 10px;">}</div> <div>           In September had an attack of hemiplegia (left limbs and face).            Recovered well from the paralysis, but not completely.            Became liable to pain and spasm in lower limbs.            My first consultation.         </div> </div>
1886	49	
1887	50	
1888	51	
1889	52	
1890	53	
1891	54	
1892	55	
1893	56	

His account of the seizure was that he had risen one morning in usual health and was dressing, when he found suddenly that he could not use his tongue. Soon his left arm and leg failed, and he had to be assisted back to bed. He did not lose consciousness in the least, and had no difficulty in finding his words, but could not enunciate them. The left side of his face was paralysed. Some warnings of the fit had occurred. He had been sleepless, and had felt uncomfortable in his head. On one occasion he had been unable to draw his left hand out of his trouser pocket.

A peculiar feature in the case was that about a year after the attack of hemiplegia he became liable to distressing pain in the affected lower limb. This pain was attended by contraction of the knee and foot; the latter assuming the varus position. The attacks of pain always came on during sleep, and obliged him to get up and walk about. He would often be thus compelled to rise ten or fifteen times in the night. If he went to sleep in the daytime he was sure to wake in pain.

When he consulted me his left foot was turned in and the knee constantly bent. His knee-jump was moderate on both sides, better on the left.

The liability to pain did not begin till a year after the attack of hemiplegia. He still had a lumpy condition of the middle of tongue. Many scars on the scalp. He said that anything which took his whole attention exempted him from pain, and even the contraction at his knee might pass off. Thus, whilst playing at billiards he was free from pain, and sometimes his knee would become quite straight. All the muscles of the inner hamstrings were thrown into contraction if he endeavoured to straighten the knee. The muscles were well nourished. His upper extremity was, like the leg, somewhat stiff, but it was not liable to pain.

In the case above given, it is clear that we have to choose between hæmorrhage and thrombosis as the cause of the hemiplegia. The attack was sudden, and developed rapidly. It had, however, been preceded by some temporary weakness in the left arm, and this, taken with the fact that there had been discomfort in the head, may perhaps give support to the belief that it was arterial thrombosis rather than rupture. The long interval which had elapsed since the attack of syphilis would, on the other hand, suggest such kind of arterial disease as would more probably cause rupture than plugging. It may even be doubted whether the syphilis had any direct connection with the attack. The latter may have been from senile disease of arteries of a non-specific form. The facts, however, that definite and severe tertiary symptoms had occurred eleven years after the primary disease, and some of a more or less vague character had persisted ever since in spite of general good health, were suspicious. When I saw the patient, he had no specific symptoms excepting his tongue. His motive for seeking

advice was the painful spasms in his paralysed lower limb. Did these indicate changes of an active, possibly of a specific, kind in the scar of the hæmorrhage or the part involved by the thrombosis? Possibly they were in connection with irreparable damage, but implied nothing whatever as to recent activity. It seemed best, however, to be on the safe side, and although he had no headache, to use specifics again. He reported that mercury had always agreed with him, and that the iodides always lowered him and irritated his kidneys. It was, however, from the iodides that he had always obtained most relief to his pain.

I advised him to push mercury. This was done to slight ptyalism, and with the result that an old osseous node on one tibia became more swollen and painful. It subsided again when we left off mercury and gave iodides. When I last saw him no great benefit had been obtained as regards the spasms.

*(To be continued.)*

## NOTES ON THE DISTRIBUTION OF HAIR ON THE HUMAN BODY.

ALTHOUGH in the gradual progress of race-development the hair bulbs have atrophied over the greater part of the surface of the human body, yet man can by no means be correctly described as a naked-skinned animal. Those who have frequent occasions to make their patients strip, or in other ways have opportunities for seeing unclothed men, must often be struck by the remarkable peculiarities displayed by individuals as regards the local or general growth of hair. It may perhaps be worth while to briefly take note of these peculiarities, since it is quite possible that their study may convince us that they illustrate laws to which some degree of practical importance attaches. In order to avoid prolixity I will not attempt a continuous essay, but content myself with recording a few detached observations.

The suppression of the hair bulbs as regards the surface of the trunk and limbs is far more nearly complete in females than males. Hairy men are tolerably common, hairy women exceedingly rare.

To some extent the growth of sexual hair is the same in the two sexes. By sexual hair we may suitably mean the hair which does not make its appearance until the sexual functions are developed. Both in men and women at the period of puberty hair makes its appearance in the axillæ and on the genitals, and its luxuriance is in some relation with the vigour of the newly assumed character.

In males, however, not only does hair grow on these regions, but it appears on certain parts of the face, and in many persons in greater or less abundance over the trunk and limbs also. The hair which some persons show so plentifully on



the chest, back, and hips, &c., must be regarded as sexual hair, for it is never present before puberty, and is chiefly seen in those who are vigorous.

There is a curious proverb which asserts "There is no wife for a hairy man." Whether it means more than that such a man will not be able to find a mate in like condition, I do not know. There is probably no ground for suspicion that hairiness renders a man in any degree distasteful to the other sex.

The regions on which, in men, aberrant sexual hair is developed vary much. Perhaps the one most frequently affected is the middle of the chest, but the back, the loins, the thighs, and the backs of the arms may in turn be affected. Sometimes the back and chest are bare and the buttocks covered.

In many men the facial hair may be not confined to the chin, cheeks, and upper lips, but great tufts of strong hair may grow inside the tragus of the ear, or just within the nostril. I do not think that I ever saw hair in these positions in women.

The suppression of hair on all parts of the face in women, eyelashes and eyebrows excepted, is often remarkably complete. Unless with the approach of senility and abeyance of sex character, or in states of sexual ill-health, nothing but the most delicate down can be detected usually on a woman's face. It may be thought that hair in the entrance to the nostrils and the external ear is likely to be valuable as a protection, but most women have to get on without it, just as certainly as they have to forego the warmth of a beard in front of their throat.

The growth of the eyelashes is probably much the same in the two sexes, but that of the eyebrows is always restrained in women, whilst in some men it is free and becomes decidedly a sexual character.

In association with the completeness of the suppression of facial hair in women, we observe its profuse growth on the scalp. The male scalp cannot, as a rule, compete with that of females in respect to the abundance and length of its hair. Probably, also, the growth of hair is more rapid in

women. The capability of growth to an almost indefinite length must probably be regarded as a sexual peculiarity in women, for very few men could in any degree rival it.

It seems not improbable that there is some law of local competition which restrains the growth of hair, and it may be that the absolute suppression of hair on the face, trunk, and limbs in women conduces to luxuriant growth on the scalp.

I feel sure that it is the fact that in men the growth of hair on the face and trunk competes with that on the scalp. Hairy men are usually bald men, and so very often are bushy-bearded men.\* The explanation of this may perhaps be that the hair requires for its sustenance certain elements of food that there are not supplied in unlimited quantity.

I think I got the hint from Dr. Mapother that it might be possible to feed the hairs and promote their growth by a suitable diet. We know that we can feed the fat and the muscles. Although vegetable food can of course be used to make both muscle and hair, yet it does not follow that some nearly similar articles of diet may not be, in certain states of the system, more readily available. Possibly some enterprising chemist might prepare for us a crinal extract from which to make a hair-soup.

In some cases in men the whiskers are not limited to the sides of the cheeks, but come forward over their middles and cover the flush-patches.

There is in the Leeds Pathological Museum an example of an acephalous, or rather brainless, fœtus, the whole body of which is covered with downy hair. I have seen several instances in which the occurrence of severe disease in

\* When I was a boy, electioneering amenities did not entirely prevent personalities. I well remember some doggerel rhymes in which the members of a local committee were described and "taken-off" by an opponent. Of one gentleman whom I knew well it was said (quite truthfully)—

"Where the soil's unproductive the hairs are thin,  
But nature has doubled the growth on his chin."

A gentleman who was recently under my treatment for syphilis lamented bitterly that he was becoming bald. I had noticed that his buttocks were covered thickly with long, curly hair, but the suggestion that he could not expect to have it grow equally everywhere did not seem to console him.

infancy (chiefly, I think, cerebral) has appeared to favour the growth of hair on the body. It may be conjectured that brain disease may in some way arrest the development of parts of the system which in a reflex manner may be supposed to inhibit the development of body-hair.

Any protracted and debilitating disease, in a young person, may be attended by a general growth of weak hair over the body. This may occur in either sex.

It may perhaps be held to be the law that the more perfect the sexual health in a male, the greater the luxuriance of hair; whilst in the female the more complete is its suppression. There are, however, exceptions on both sides.

In some persons a broad band of strong sexual hair passes down the middle of chest and abdomen, and, widening as it descends, joins with that of the pubes. Those who have hair in this position rarely have it on the back also.

The pubic hair is usually the same colour as that of the beard, and both may differ from that on the scalp and abdomen. I have seen a plentiful crop of black hair on the abdomen from navel to pubes, that on the pubes and that of the beard being red.

There will, I think, be little doubt that hairy persons are usually of the dark complexion. I do not think that I ever saw a fair-haired individual with any very remarkable development of hair on the trunk or limbs. This may be a matter of race. The Semitic race, as represented in England, is, I think, far more prone to the growth of body hair than any other, and most Jews are of dark complexion.

## ON CURVING OF THE PENIS.

THERE is a peculiar affection of the penis, very annoying to those who suffer from it, which consists in a tendency on the part of the organ to curve upwards during erection. The curving is not attended by any pain whatever, but it is often very considerable and may be sufficient to entirely prevent intercourse. The subjects of this malady are usually men past middle age, but still in the vigour of life. It is in my experience quite exceptional to find any special cause assigned for it. Now and then there is, as we might expect, a history of syphilis in youth; and very often there is, as also might be expected, a history of gout in the family. It is but seldom, however, that either the one or the other of these affections appears to be definitely connected with the symptom.

On examining the penis in these cases there can generally be appreciated some unevenness in the structure of the corpora cavernosa. Either there is a spot, which is less firm than the rest, or there is a part which is decidedly indurated. These conditions are, however, often far from being conspicuous. We may, notwithstanding, I think, accept them as sufficient evidence in support of the belief that the pathological condition is sometimes an obliteration of the cavernous structure of the organ. We may conjecture that in these cases local thrombosis or inflammatory induration is the first step in the malady. It is but seldom, however, that the patients can give us any help in this direction by assigning the date of the occurrence of any such attack. I have seen from time to time a good many examples of this peculiar malady; and the statements made above present, I think, a fair summary of what I have observed. Some of the patients have been very much distressed by the symptom, and willing to persevere

with any treatment which promised relief. Treatment usually has, however, been very unsatisfactory, and in several cases I know that the symptom persisted for several years, and that no benefit had been obtained when the patient was last seen.

A valued correspondent (who withholds his name) has suggested to me that there may be some connection between this symptom and the induration of palmar fascia of the hands known as Dupuytren's contraction. He has observed two cases in which these conditions were present together. It is a suggestion well worth attention, and I am sorry that in most of my cases I have not noted anything regarding it.

The following are some brief records of examples of this condition which I find in my note-books :—

CASE I.—*Curved Penis in an old man.*

In June, 1884, an old man of seventy-two, who had been fifty years married, consulted me on account of this symptom. It had troubled him for a year and a half, and was increasing. I saw him but once, and have no note as to any induration of the part.

CASE II.—*Curving of the Penis in a man of middle age.*

In a case in which I was consulted by Mr. I—— S——, of H——, the patient was a man who had been twice married and who in early life had had syphilis. He was fifty-three years of age. For five months he had experienced great inconvenience in intercourse owing to the penis curving upwards when erect. The curve was greater during the advent of erection than when it was complete. He attributed it to having exerted himself too much in intercourse when excited by wine. As these occasions were, however, attended by pain, it is probable that they were rather the occasions for his discovering what had really been present in some degree before. He was a nervous man, and the condition had caused him great annoyance.

In this case the patient himself had never suffered from gout, but his father had had it severely.

Three years after my first consultation Mr. S—— was good

enough, in reply to my inquiry, to inform me that in both palms a decided tendency to contraction of fascia existed. The curving of the penis was still present, but the pain had ceased. During the last two years he has been under treatment for a rheumatic affection of his eyes.

CASE III.—*Induration in the Penis in an old man of sixty-six.*

In September, 1874, I saw a hale old gentleman of sixty-six who was troubled with the condition under discussion. In the middle of the upper part of his penis was a considerable indurated mass. It caused contraction rather than enlargement. It began a little behind the glans and extended back to within a little distance of the pubes. It had been attended by no pain, but in erection it caused the penis to bend upwards and entirely prevented copulation. He was married, and much lamented his condition. I saw him only once.

CASE IV.—*Bending of the Penis—Induration and Shrinking of one Corpus Cavernosum.*

Mr. K——, aged 59, had suffered from stricture after gonorrhœa; had used instruments often. He consulted me in August, 1881, on account of induration and atrophy of the right corpus cavernosum. It caused the penis, during erection, to curve upwards and to one side. His stricture when I saw him was quite cured, but his own theory as to the condition of his penis was that he might have bruised it by nipping too forcibly when passing instruments. He was the subject of balanitis perstans. An induration of the corpus was easily felt.

When I saw Mr. K—— a second time, a year and three months after the first consultation, I found that the induration had travelled backwards. It was as hard almost as cartilage, and had well-defined boundaries.

I have not seen this patient of late years.

CASE V.—*Curving of the Penis—Former history of Syphilis.*

A gentleman of fifty-six, of gouty tendencies, who had suffered from syphilis in early life, but who had fifteen

children, was brought to me by Mr. H——, of Bishop's Stortford, on account of curving of the penis. There was indefinite induration. The curving had been increasing for more than a year, and it rendered intercourse almost impossible.

CASE VI.—*Curved Penis suddenly discovered—Induration in the middle of Dorsum.*

Mr. S——, a healthy-looking Jew, aged 47, consulted me in March, 1891. One night in the previous September he had been awakened by feeling as if he had a very severe erection, and found his penis curved upwards. I found that in the middle of the dorsum of the penis, apparently implicating both corpora cavernosa, was a disc of induration as hard as cartilage, which caused the glans to be curved upwards during erection. When first noticed it was, he said, merely "a single, little, hard knot like a pill."

At the age of seventeen, Mr. S—— had had a very severe attack of gonorrhœa, with very painful chordee, but had been free from the disease recently. I could obtain no definite history of gout; but a brother and sister, both living, were the subjects of diabetes. The patient was liable to aching across the eyes. He had seen Mr. Berkeley Hill before coming to me, who had considered it gouty.

This patient, at my request, came for examination a second time, March 5, 1894. The state of things was much as at first. He could still effect connection, but described the curving as being great. The corpora cavernosa appeared to be wasted, and there was a hard band in the middle (the septum), which he said became more conspicuous during erection. He had no trace of Dupuytren's contraction of palmar fascia.

I cannot forbear to quote this patient's version of what my late much-valued friend, Mr. Berkeley Hill, had said to him. It was as follows: "I have seen about six cases like yours, and if you have come expecting me to cure you, I must tell you candidly that I cannot, for I never saw improvement in any one of them."

CASE VII.—*Curving of the Penis in a man of middle age—  
Shrinking of the Corpora Cavernosa.*

In the case of Mr. M——, aged 42, the condition was, contrary to rule, associated with some loss of sexual power and desire. I saw him in 1885 and 1886. He was a short, muscular man of good energy, but he admitted that, apart from its being almost impracticable on account of the upward curving of the penis, he had very little desire for sexual intercourse and that erections occurred but seldom. His corpora cavernosa were hard and apparently somewhat wasted, so that the glans and corpus spongiosum appeared too large, and thus more or less of curving was constantly present. The penis was small, and the scrotum tightly contracted on the testes. The inconvenience from curving in erection had been present three years when I was consulted, and of late he had been obliged almost wholly to abstain. He had formerly lived a very fast life, and had suffered from both gonorrhœa and syphilis. There were no conclusive symptoms of commencing tabes, but his knee-jump was defective and micturition-power feeble.

CASES VIII., IX. & X.—*Cases of Curved Penis in association  
with Dupuytren's Contraction of Palmar Fascia.*

An observer to whom I am indebted for some particulars respecting three cases of this kind, writes me that he has, in two of them, carefully re-examined, at my suggestion, as to whether induration can be detected. In neither can anything whatever be identified when the penis is lax, but in one, when erect, the patient discovers "a small cord passing backwards two inches in length." Both of these patients are the subjects of Dupuytren's contraction of palmar fascia.

The following is an extract from a former letter from my friend on the subject:—

"Within the last twelve months I have met three cases, with regard to which I can find no reference in any book in my possession (and no medical brother I have spoken to has seen a case), and I hope you will forgive me asking you to help me in the matter.

"All these are married men over middle age, and fathers of families.



There is no history of syphilis, but two are rheumatic and one probably gouty. Two have Dupuytren's contraction in both hands.

"What they complain of is, that when there is an erection of the penis, it becomes curved towards the abdomen so as to make it most difficult to have connexion with their wives. The curve, which they describe as acute, is situated close behind the glans. Most careful examination of the organs reveals nothing. They can be pulled forward without any difficulty, and without showing any shortening band. There is absolutely, so far as I could make out, nothing abnormal when there is no erection. There is no pain in erection, nor is there any narrowing as of want of expansion of the cavernosa. They are all potent, and say that the difficulty of insertion overcome, they are as good as ever they were. They say that the condition developed in a few weeks, and has since remained stationary."

CASE XI.—*Curved penis, with some thickening in the cavernous bodies.*

Captain E. B. A——, a married man, aged 50, of healthy family and himself in vigorous health, consulted me in April, 1889. About a year previously he had noticed pain at the root of the penis during coition, and the act had become difficult. When in the morning he sometimes still had erection, the penis was not straight, but curved upwards and in a condition of painless chordee. I found on examination that there were ill-defined lumps in the corpora cavernosa at the root of the penis.

GENERAL COMMENTS.

Although this subject has at yet received but fragmentary mention, it is by no means novel. Mr. H. J. Johnson, in 1851, described "a chronic inflammation of the corpora cavernosa," and probably some of his cases were of the same nature as those which I now adduce. In most of my cases, however, no sort of "inflammation" or of "tumour" had preceded the annoyance of curving. Sir James Paget, in his admirable lectures on Gouty Affections of the Genital Organs, published in 1875, has anticipated, by suggestion, almost all that I have here said. He comes, indeed, very near to the hypothesis that the cause may in some cases be a contraction of fascia analogous to that which occurs so

frequently in the palm of the hand. His words are, "In gouty persons the production of fibroid tissue, thickening and contracting the outer layer of the urethral wall, and thus producing stricture, seems to be a process of the same kind as the thickening and contraction of the palmar fascia of which I spoke in the last lecture. Or it may be more nearly compared with that very troublesome, and generally gouty, thickening and hardening of portions of the fibrous sheath of the corpus cavernosum, which produces distortion of the penis in erection, and sometimes frightens with the fright of cancer.\* Tough bands or lumps of such fibroid tissue may be felt on either side, or, more commonly, on the dorsum of the penis, or in the septum; and because they will not yield as the rest of the structures do to the erecting pressure of the blood, they hold the penis rigidly bent on them, as in a chordee." By far the most detailed clinical account of this affection is, however, to be found in Van Buren's excellent treatise on Diseases of the Genito-urinary Organs.† This author (page 23) first describes calcification of the fibrous sheath of the corpora cavernosa, a condition "which causes erection to be imperfect and painful." This condition is possibly a rare sequel of some forms of inflammation attributed to gout. It

\* The following extracts give us, in the first place, a very characteristic example of the malady, and in the second a confirmation of Paget's statement that a suspicion of cancer is often aroused :—

On page 765 of the *British Medical Journal*, 1886, I find, under the head of queries, the following :—" *Gouty Infiltration of the Penis*. F. R. C. S. writes : ' A person subject to gout, the wrong side of fifty, has a thickening occupying the upper surface of the penis. When erection or partial erection takes place, the organ is curved backwards. There is no pain nor difficulty in micturition, but the glans and body appear to be atrophied to some extent. Sexual desire is not impaired, but intercourse has not been practised since the present condition has existed, now some years. It appeared to come on gradually after a prolonged gouty attack.' "

In the *Journal* for May 8 the following occurs :—" *Gouty Infiltration of the Penis*" (under signature G. W. B.) " Presuming that F. R. C. S. writes for advice as to the treatment of the above, I may say that I was acquainted with an elderly gentleman with so pronounced and hard an infiltration of a similar character to that which F. R. C. S. describes, that a distinguished Scotch surgeon looked on it as cancerous, and wished to remove the offending member. Nevertheless, it entirely disappeared under the prolonged use of full doses of iodide of potassium, given for another purpose."

† Clinical Lectures, page 380.

is probably very rare, and I do not remember to have ever myself recognised it. Next he describes a "Chronic Circumscribed Inflammation of the erectile tissue of the corpora cavernosa." This disease is stated to be very insidious, and to be characterised by the presence of "a hard flattened mass with distinct, sharply defined margins, occupying the substance of one or both corpora cavernosa near the surface, and feeling like cartilage." He adduces in some detail five interesting cases, in three of which the history of syphilis was wholly absent. Although he writes, "the prognosis is good," this must be taken to refer only to the patient's health, and not to his marital inconvenience, for none of the cases would appear to have recovered in that direction. In one case two brothers suffered. In all the cases a lump was noticed. Dr. Cameron, quoting from Van Buren, says that in one of the latter observer's cases the palmar fascia was contracted; but in my edition no mention is made of this interesting fact.

In 1879 the late Mr. Callender\* produced at one of the St. Bartholomew Hospital consultations a man aged 50, in whom an induration was stated to have begun in the glans and extended backwards in one corpus cavernosum. It had not passed the septum pectiniforme. It had subsided where it first began. There was no history of syphilis or of hæmorrhage, and there had been no pain. Mr. Callender thought it possibly malignant, but Mr. Savory thought it more likely "gouty phlebitis."

Dr. Hector Cameron, of Glasgow, published some interesting remarks on these cases in the *Lancet* for 1884.

Although I have not refrained from quoting from authors who have described only inflammations and indurations, yet the special subject of my paper is the curving of the organ which constitutes such a troublesome symptom, and my contention is that it is by no means always preceded by infiltration of any kind. This is a point which seems as yet to have escaped attention, and these cases possibly constitute a group by themselves. On the other hand it is to be admitted that

\* *British Medical Journal*, 1879, vol. i. p. 663.

all forms of chronic infiltration, whether phlebitic or of cellular tissue, are likely to be productive of curving, and that the line is very difficult to draw between the cases preceded by thickening and those in which the curving appears to be primary.

Our cases may perhaps be divided into the following groups.

I. Those in which no appreciable induration attends the symptom of curving. In these it may be conjectured that a shortening of parts of the fibrous sheath, or septum, analogous to what is observed in Dupuytren's contraction is the cause. It is of much interest to note that these cases occur at the same age as those in which the palm is involved; that in one case at least the condition has occurred to two brothers; and lastly and of chief importance, that the two disorders are not infrequently present together. An inherited tendency to gout is probably an antecedent in many cases.

To this group ought also to be assigned certain cases in which ill-defined, lumpy thickening is present; for it is well known that in the palmar contractions there are often masses of fibroid hypertrophy as well as a state of shortening.

II. In a second group we may place cases in which rounded well-defined swellings are identified which do not much tend to advance or vary. The true pathology of these is as yet uncertain. They are very rare.

III. In a third group must be placed cases in which definite induration of one or both corpora cavernosa has shown a tendency to advance, leaving the part behind it in a state of atrophy. It is in this class especially that something of the nature of thrombosis of the erectile tissue may be suspected. Only one corpus may be involved, and the curve will then be lateral instead of dorsal.

As regards treatment, we may probably say that it is only in cases in which there is definite swelling that benefit can be hoped from mercury or iodides, and in such these remedies ought certainly to have a trial. Whatever we may believe as to gout as a remote cause, we cannot be sanguine as to the result of enforcing any regimen or prescribing any special drug. After Dupuytren's contraction has once set in, no treatment except by operation avails anything to arrest its progress.

It seems not improbable that a large majority of cases of curved penis belong to this category.

In future we should note carefully the state of the palms in all cases of curved penis, and conversely it may be of interest in cases of Dupuytren's contraction to inquire whether any difficulty has been experienced as regards this organ.

## ON ARSENIC-KERATOSIS AND ARSENIC-CANCER.

To the clinical observer nothing is more gratifying than to find his results confirmed by others. This pleasure has recently been my own in respect to the occasional tendency of long courses of arsenic to induce changes in the skin leading to epithelial cancer. When I first recorded certain facts giving support to this belief, few, I suspect, were inclined to admit that the occurrence was more than a coincidence, and nearly ten years have elapsed without any additional evidence being forthcoming. At a recent meeting of the Clinical Society, however, Mr. Arbuthnot Lane brought forward a very definite case. The patient had taken arsenic for thirty years for the relief of psoriasis, and he had finally become the subject of multiple growths of epithelial cancer.\* The growths (which had been excised, and were demonstrated to the meeting) showed the usual conditions in the most typical manner.

Another case has also come under my notice. A gentleman of thirty-five has had three growths excised during seven years, all of them showing the structure of epithelial cancer. He is also the subject of keratosis of his palms,—in the form of hardened spots and patches of epidermis and little corns,—exactly such as was present in my first cases. His first growth was in the palm, near the cleft of the index and middle finger, just the position which was affected in one of my former cases. Two of the growths in this case have been excised from the scrotum. I removed one of these myself two months ago. It was very small, not much bigger

\* This statement applies only to cases of actual cancer. Cases supporting the statement so far as it concerns keratosis of the palms and soles have been observed, and I believe that most dermatologists now accept it.

than a pea, but its structure has been pronounced characteristic by several authorities. This patient's history as regards arsenic is peculiar, for he left off its use many years ago, and the tendency to local keratosis still persists. He is now thirty-five, and he took arsenic when a young man for the cure of acne. He does not know how long he took it, but supposes that he "had twenty bottles." Nothing occurred whilst he was taking it, but not long after leaving it off a crop of little wart-like indurations appeared on his scalp, and were followed some years later by corns in the palms of his hands. It was not till ten years after he had left off the drug that one of these corns assumed malignant tendencies, and excision was required. Six years later another growth required the same measure, and, as stated, quite recently a third. On all occasions a careful microscopic examination has been made. It may be admitted that in this case, if it stood alone, the interval between the arsenic taking and the development of cancer is so long that some scepticism is permissible as to whether they were really cause and effect. It must be remembered, however, that the case is exactly like the others; that multiple epithelial cancer at the age of thirty-five is exceedingly rare; and that the stage of keratosis was developed not very long after the arsenic was disused. No similar cases have, so far as I know, been recorded, except in connection with arsenic, and it may be that the patient's memory as to the date at which it was left off is not accurate.

By the courtesy of the author, I have just received from Dr. Giletti, of Turin, a copy of a beautifully illustrated report on a case of "Symmetrical Kerato-dermatitis" affecting the palms and soles. His patient was a man aged 25, in good health, for whom, on account of an erythema of the palms (diagnosed "urticaria") following typhoid fever, Fowler's solution was prescribed in 1889. He took the remedy continuously up to March, 1893, when, for the first time, he came under Dr. Giletti's observation, with his palms and soles in a state of disseminated keratosis. The conditions shown in the plates are in most respects like those which were present in my own arsenical cases. A microscopic section

shows great thickening of epidermis, and no disease of papillæ or glands. This again is exactly what was present in my cases.

Dr. Giletti does not put his case into the arsenical group for several reasons which he states, but to no one of which, I may confess, can I attach importance. The first is that the disease continued to increase for two or three months after the arsenic was left off; the next that it remained in *statu quo* ten months later still; and, lastly, that he supposes (in error) that I found, and considered pathognomonic, "a crateriform enlargement of the mouths of the sudoriferous glands." As regards this last, it is the first that I have heard of it; and, as regards the others, it was deemed a not unimportant part of my observations that the conditions did progress after the arsenic was laid aside. I must therefore claim Dr. Giletti's case as in every way similar to my own, and in all probability due to arsenic. It is one in which not improbably cancer may follow.

Dr. Giletti quotes the case published by Hans Hebra as "Keratosi verrucosa palmæ, etc.," in "Arch. f. D. N. S.," 1890. He is apparently not aware that subsequently to its publication it was discovered that this patient, a young woman, had been secretly taking arsenic for many years. (See ARCHIVES, Vol. IV. p. 186.)



## CONGENITAL DEFICIENCIES IN THE PECTORAL MUSCLES.

A YOUNG man, Mr. C——, who came under my treatment for syphilis, and whom I asked to strip, exhibited a very remarkable peculiarity in his chest. There was a large hollow under his left clavicle, which at first suggested either a badly united fracture of the bone or depression of the ribs. On examination, however, I found that it was due entirely to absence of the great pectoral muscle. A large development of the deltoid made the hollow yet more conspicuous. The patient was not fat, but very muscular, and accustomed to box and practise athletics. His clavicles were short and very strong. He referred the condition to his infancy; so far as he knew it had always been so. On examining his back, I found that the latissimus dorsi was alike wanting. The pectoralis minor was also absent, and possibly the teres major. About the latter I was not certain. Mr. C—— said that the defect caused little or no inconvenience; he could box well, and lift heavy weights above his head. In accomplishing the latter, he said that the difficulty arose in getting his arm above a right angle with the trunk; in doing this he was obliged to throw his body on one side. This disability, it may be remarked, is only an exaggeration of what is always experienced in performing this feat.

I made a demonstration of this patient in my lecture at the Clinical Museum on February 6th. The man then drew our attention to the fact that, when making a very strong expiration, he could, as he said, make his lung come out. Just to the left side of the sternum, between the first and second ribs, there was a rounded hollow, apparently due in part, at least, to deficiency of bone. At this spot he could quite easily produce a rounded, soft swelling the size of a

half walnut. The intercostal tissues were probably deficient at this spot.

We verified on this second occasion the facts which I have previously stated. The man could bring his arm forwards so as to touch his opposite shoulder with his hand. He appeared to do this by means of the anterior part of the deltoid.

Several parallel cases are on record, but no two are exactly alike in detail.

1. In a case shown by Dr. Burney Yeo at the Clinical Society in 1873, the sterno-costal portion of the great and the whole of the lesser pectoral were absent on the right side. The clavicular portion was hypertrophied. The radial pulse was very small.

2. Mr. Taylor, of Guildford, has observed a case in a volunteer in whom the whole of the great pectoral on the left side was absent.

3 and 4. Mr. Nunn has mentioned two cases, in one of which some deficiency of the latisimus dorsi existed.

5. Mr. John Tweedy has record in the *Lancet*, in which, as in Dr. Yeo's case, the thoracic portion of the great pectoral was absent together with the whole of the lesser pectoral. The clavicular portion of the great pectoral was hypertrophied.

6. Dr. Young, of Okehampton, has published in the *Lancet* for January 6, 1894, a case with illustration, in which the sterno-costal portion of the muscle was absent on the left side. There was also partial webbing of the fore and middle fingers on the same side.

7. Reverdin has published in "Bull. Soc. Anat.," 1867, p. 584, a case in which both pectorals were absent, together with deficiency in the cartilages of the third and fourth ribs.

8. Dr. Féré, in his work "La Famille Néropathique," gives woodcuts from a dissection of case in which the great pectoral was defective, and the lesser one wholly absent (p. 276).

9. Mr. Poland has published in the Guy's Hospital Reports a case, with a lithograph, showing the dissection of the region. The clavicular portion of the great pectoral was present, but the other part of the muscle and the lesser pectoral were

wholly absent. The serratus magnus was to a large extent deficient, and there were malformations in the left hand. There were peculiarities in the external oblique muscle. All the defects were on the left side. This case is very valuable on account of the completeness of the dissection and record. The latissimus dorsi was present.

10. In the *Lancet* for 1873, Dr. Forsyth, of Darlington, records the case of a man of 18 in whom the great and lesser pectorals were wholly wanting.

11. Dr. Willis, in the *Ohio Medical and Surgical Journal*, 1859, mentions a case in which both were absent on left side.

12. In the *Rev. d'Orthopæd.*, 1892, a case is given by Hazman, in which the great pectoral in a boy was partially absent.

13. Stern, of Budapest, 1890, gives a case of partial defect of the major and entire absence of the minor muscle.

14. In the *Archiv. f. Pathol. Anatomy*, Berlin, 1886, W. Gruber gives a case in which, in a young woman, the mamma and the sterno-costal portion of the great pectoral were absent on the same side.

Several other cases have been recorded from the dissecting room, but their details are not before me. It would appear that the deficiency has thus far, with one exception, been met with in males only; that it is equally common on the two sides, but never occurs on both; that the sterno-costal portion is more frequently absent than the whole muscle, and that the clavicular portion is never alone absent. All observers agree that the defect entails but little inconvenience. No one seems to have noticed whether in males the mammary gland is absent. It was so in the single case in which a woman was the subject of it.

In two cases, Dr. Yeo's and my own, there was some defect in the development of the costal cartilages. My own is the only case in which the whole of both pectorals and the latissimus dorsi were all absent.

## ON THE CAUSES AND NATURE OF ERYSIPELAS.

ONE of the most important questions in what may be called speculative pathology is that which concerns the apparently spontaneous origin of diseases which are sometimes contagious. Those who adopt the modern doctrines of the parasitic origin of most forms of febrile disease hold that, having once proved that a disease is attended by cryptogamic growths and may be propagated by their transference, the question of spontaneous origin is put wholly aside. For the clinician, however, there yet remain very serious doubts. Most undoubtedly many forms of disease which spread by contagion, and which appear to assume specific characters, are yet apparently capable of spontaneous origin. As good examples of such I class the diseases known as catarrh and erysipelas. Respecting both of these, I have already and on various occasions stated my belief, and endeavoured to marshal the facts which appear to me to support it. A case of erysipelas has, however, been recently under my notice which offers, I think, very instructive evidence in respect to this creed, and which encourages me to trespass on my readers' patience with a statement of the lessons which it appears to me to convey.

Before narrating the case I may just, in passing, remark that the believer in the spontaneous origin of some maladies which prove contagious is by no means compelled to accept off-hand the doctrine of spontaneous development of specific germs. We know as yet too little as to certain phases in the life-history of these germs to permit of our being dogmatic respecting them. On the other hand, we do know enough of the wonders of the cryptogamic world, of the facts as to heteromorphism and the possibilities as to long periods of

latent life, to induce us to keep our minds open and to accept with candour evidence from all sources. After all, what looks like a beginning *de novo* may be only the springing into life and activity of germs which have been long quiescent. It may be that we all of us, or most of us, carry about in our tissues latent germinal material from which, under suitable conditions, may be developed the specific and apparently parasitic elements of catarrh, erysipelas, tuberculosis, and even leprosy. It may be that these elements wait only for suitable stimulation and proper food, or that, like some of the fungi which grow on plants, they wait only till the tissue or the organism shall have received some damage which weakens the protective influence of vigorous vitality. It may be that although what we call contagion, or the actual transference of new germs in a state of activity, is much the most potent influence in arousing those already present in the tissues, it is far from being the only one capable of effecting this. We may perhaps, for the sake of distinction, call this the doctrine of latent germs. I will now proceed to examine, in the light which it supplies, certain clinical facts as regards the origin and spread of erysipelas.

In January last I had occasion to do an excision of the breast for a lady fifty years of age and apparently in good health. The operation was done in one of our largest and best managed surgical homes, and neither myself nor any of my assistants had recently been in connection with erysipelas cases. The wound was dressed with carbolic acid gauze in the usual manner. Within twenty-four hours of the operation a vivid redness of the skin was seen at most parts of the edges of the dressing. The patient's skin was in a state of intense irritation. She was quite unable to sleep, and had a certain amount of fever. The temperature on the morning following the operation was 101°, and on the evening of that day 102°. On the afternoon of the third day I removed the dressings, and found the whole of the skin where the gauze had touched in a state of the most vivid redness with superficial œdema. The edges of the wound, a very large one, were less red than the rest of the surface, having been protected by the oil-silk from the irritation of the gauze. I now applied over the whole of

the surface lint soaked in a spirit lotion, and ordered that it should be kept sedulously wet. I also administered tartar emetic in tolerably full doses. In proof that it was the influence of the carbolic acid in the gauze-dressing which had caused this extensive outbreak of erythematous oedema was the fact that the patient's forearm, which had been bandaged over the chest and had rested upon an upturned fold of the dressing, displayed a large patch of redness of a similar kind, and which rapidly proceeded to vesication. During the next week we continued the use of the spirit lotion most perseveringly, and of the antimony internally, and were fortunate enough by their aid to prevent any suppuration in the wound. Although the whole of the parts were very much swollen, red, and oedematous, yet primary union occurred throughout the length of the wound (at least twelve inches long), nor was there a single drop of pus from the drainage tube. This result I attribute to the constant use of the strong spirit lotion with which the patient was kept soaked. We may here dismiss the consideration of the wound and turn to that of the skin, which continued for some time to give us much trouble and anxiety.

The skin over the whole part which had inflamed remained red and oedematous in spite of the lotion. Vesications occurred on several parts. The feature which to my mind, however, was the most conclusive in stamping the disease as erysipelatous in nature, was its definite tendency to spread on the adjacent skin. Repeatedly the patient had slight attacks of chilliness followed by increase of temperature, and a large aggression of redness with oedema upon parts which had not been touched by the carbolic dressing. The edges of these newly invaded patches were abrupt, and the part involved pitted to the finger. Vesications also formed upon them, so that the characters of an erysipelatous inflammation were complete. The treatment required was also confirmatory of the diagnosis. Nothing checked the spread of the disease until I painted the surface freely with the ætherial solution of nitrate of silver. This was immediately effectual, and no spreading took place after the skin had been well blackened over a considerable margin in advance of the spreading edge.

I was obliged, however, to paint almost the whole chest back and front, and to follow the erysipelas as low as the upper part of the thigh. After the first week, tincture of iron in large doses was given instead of the antimonial mixture. The patient's recovery was complete at the end of a fortnight, and the temperatures became normal.\* The parts near to the operation wound were, however, for several weeks longer somewhat œdematous. Let me repeat that no suppuration whatever occurred in the wound, nor was abscess at any time threatened.

A fact of great importance in this case, and one with which I was not made acquainted before the operation, is that the patient had twice formerly suffered from attacks of "erysipelas" on one leg. On one occasion it had followed a bruise, and on another the irritation of an arnica lotion. She had had, she said, through life a most irritable skin, any slight irritation being invariably followed by swelling.

I have had at least three other cases in which the facts were in the main similar to those recorded in this instance. In each, after the incision the patient had irritation from the carbolic dressing, beginning immediately on its application. In each this irritation developed into an erysipelatous dermatitis which, with an abrupt margin and a vesicating surface, travelled over a large extent of skin. In all, the only treatment which arrested its spread was the use of the nitrate of silver solution. In all, the inflammation ended without suppuration of the wound itself. In none of the cases was the constitutional disturbance very severe, although in all it was very definite. In one of them, nearly a week after the local

\* The temperatures were on the day after the operation, 102.

Third day, 101·9.

Fourth day, 100.

Fifth day morning, 99; evening, 105.

Sixth day morning, 99; evening, 100.

Seventh day morning, 99·5; evening, 100·2.

After this date it continued but little above normal for a week. On the fifteenth and sixteenth days in the evening it was 100 again, and on the seventeenth day 102. This was coincident with a fresh invasion of erysipelas, which was put an end to by a free painting of nitrate of silver, after which the disease came to an end and the temperatures continued normal.

inflammation had apparently come to an end a blush of erysipelas appeared on one thigh and travelled down the limb some little distance before it was arrested by the nitrate of silver.

It may be convenient, at this point, to take a brief survey of the facts respecting erysipelas which have been ascertained by experimenters, in order that we may see how they fit with the observations of clinicians. The investigations of Dr. Fehleisen, supported as they have been by others, appear to place beyond doubt that "true erysipelas may be propagated by means of a micrococcus which is capable of cultivation."\* It is a chain-forming micrococcus, quite immobile, and is found in great abundance in the lymph-spaces and lymph-vessels of the skin. Fehleisen did not find it in the blood, nor in the serum of vesications. With this micrococcus cultivated up to the seventeenth generation, the artificial production of erysipelas was repeatedly effected not only in the ears of rabbits, but in the human subject. In the latter it was tried in cases of cancer and lupus, in which it was hoped that the erysipelas might be of benefit. The most effective plan was found to be to scarify the part, and then rub in the virus. Mere punctures often failed, and the activity of the contagion did not appear to be very great. In rabbits the induced disease was mild and transitory, but in the human subject severe constitutional disturbance and high temperatures resulted, and in one at least a fatal result was threatened. Fehleisen makes it an important point that what he calls true erysipelas restricts itself to the skin, and does not cause suppuration, or spread to the cellular tissue. The shortest incubation period was 15 hours, and the longest 61. The appearance of local redness and the first rigor usually coincided. Seven persons were inoculated, and six took erysipelas. The seventh, who was twice inoculated without success, had had frequent attacks of erysipelas before the last, only two or three months before.

As regards immunity conferred by an attack, Dr. Fehleisen

\* See New Sydenham Society's volume, "Micro-parasites in Disease," p. 260.



came to the conclusion that there was a short period. In several instances in which patients had suffered not long before, inoculation failed; but in one it succeeded, in October, 1882, in a patient who had suffered from erysipelas in December, 1881.

It will be seen that we are now face to face with the question, What is erysipelas, and to what extent shall we restrict or enlarge the meaning of the word? Very far indeed, however, is the question from being a merely verbal one. It concerns things which are of the utmost importance in our clinical work. According to the conception of the experimenter, erysipelas is an inflammation affecting the skin, only spreading from the point at which inoculation has been effected, of transitory duration and without complications. Some experimenters would definitely exclude all forms affecting the cellular tissue, and deny that phlegmonous erysipelas is erysipelas at all. It may be well to review the facts as seen from the clinician's point of view.

The practical surgeon recognises as erysipelatous all forms of inflammation of skin or mucous membranes which show a tendency to rapid spreading in the tissue affected, have a well-marked edge, produce œdema and vesications, and leave the part first affected as they travel to others. He believes that erysipelas may affect the cellular tissue, and that when it does so it may cause diffuse suppuration. He believes that if the erysipelas has begun superficially, *i.e.* in the skin itself, it will probably restrict itself during its spreading to the skin; but that if it have commenced in the cellular tissue (from a deep wound), it will spread in the cellular tissue. He holds also that the form of endo-metritis with peritonitis constituting puerperal fever, may be caused by the introduction of the erysipelas virus. In connection with these cases and many others, he believes firmly that the specific virus may, in spite of all ordinary cleanliness, cling to a surgeon's hands and clothes for many weeks. As regards the origin of the disease, he by no means holds that it is always due to infection, since very severe and even fatal cases often appear to originate from exposure of the surface to cold or other influences which

lower the vitality or irritate the tissues. He does not see in erysipelas a malady which, like variola, measles, &c, prevails only in epidemics, but encounters it in isolated cases under very various conditions. Indeed, although fully recognising its contagious nature, he does not regard its more ordinary forms as being virulently contagious. He holds it for a well-established fact that those who have once had erysipelas remain through life more liable to fresh attacks than other persons, and believes that these recurring attacks are specially apt to occur in the same part which was first affected. Thus, in patients the subjects of elephantiasis, he recognises periodically recurring attacks of erysipelatous inflammation as the main cause of progressive aggravation. Finally, he recognises in "erysipelas" a form of contagious inflammation which may vary much in type, being sometimes very severe and attended by high fever, at others very mild; and at the same time he believes that all its forms are transmutable.

From what has been just said it may be inferred that the surgeon would prefer to speak of erysipelatous inflammation rather than of "erysipelas," the latter suggesting too much of specificity and of sameness in the malady in question. Whilst by no means wishing to diminish the importance of the bacillus in the rôle of phenomena, he is disposed to accept with caution the inferences which may appear to be logically deducible from its discovery. For the present, at any rate, he dare not place it in the same category as the specific virus of small-pox or syphilis. He cannot help suspecting that, although susceptible of pure cultivation, it is yet also capable of considerable modifications as regards its vital endowments and activities, that it may not improbably lie dormant in the tissues for indefinite periods, and that it may combine with other forms of virus and produce mixed results.

The alternative of accepting some such creed (of modifiability) as this appears to me to involve the existence of a number of distinct specific poisons—one for erysipelas as we see it on the head and face from cold, another for that following external irritants (such as in the case which I have narrated), a third for that of traumatic erysipelas of the sk

a fourth for that of phlegmonous erysipelas as it affects the cellular tissue, and so on.

I confess to a distinct belief that the one supposition fits the facts far better than the other. The proof, of course, lies in the production of evidence of transmutation and communicability. In the case which I have narrated, the utmost precautions were taken against contagion, and none occurred. Thus we lack the proof which the production of the disease in another person would have afforded that the poison of true erysipelas was really present. Nor were any inoculation experiments tried. It is therefore not possible to put on paper evidence of this kind, and it is open to the controversialist to hold that the malady, after all, was not "erysipelas." I may repeat that I know of no external characters by which the form of dermatitis which occurred could be distinguished from it, and may add that, from other cases which have from time to time occurred in my practice, I have no doubt that, had precautions been neglected, the disease would have spread.

## DISEASES OF THE SKIN.

### No. LXXXII.—*Two cases of Herpes affecting the inferior Dental Nerve.*

The distribution of herpes is often well worthy the observation of the anatomist. I have just seen two cases in which the mental branch of the inferior maxillary was the nerve affected. This is in my experience very rare. In association with it occurred some small groups of vesicles on the cheek, near the ear. In the two cases the distribution was exactly alike.

The first of the cases was sent to me at one of my Tuesday afternoon lectures by Mr. Waren Tay. The patient was a woman aged thirty-six. Without any known cause, the right half of her chin became covered with herpetic vesicles, which afterwards sloughed. There were some on the lip and a few in the cheek. It was two months after the eruption when I saw her. Deep scars had been left which involved exactly the region supplied by the mental nerve and no more. Upon the cheek, however, a little in front of the ear, there were two isolated conspicuous scars, one a little above the other. There were none on other parts of the face. It was said that there had been some spots on the tongue, but of these no traces remained.

The subject of my second case was a young lady of twenty, for whom, on account of psoriasis, I had ordered full doses of arsenic three weeks before her attack of herpes. She came to me on December 21st, with the right half of her chin and lower lip covered with ulcerating vesicles. There were ulcers on the inside of the lip, but the eruption was, with the exception about to be stated, precisely limited to the region of the mental nerve. The exception consisted in the presence of a

single isolated group as large as a shilling, but oval, with vertical axis upwards, on the cheek. It was exactly an inch in front of the tragus of the ear. There were no other groups on the face. There could be no doubt that in this case the herpes was caused by the arsenic. It is of interest to state that although it was severe it had been almost painless, and that both the patient's parents had suffered from zoster in former years.

It is not difficult in these cases to explain the occurrence of herpetic vesicles on the parts where they are seen, for branches of the inferior maxillary are known to be supplied to all these regions. The difficulty is to say why so much of the territory of this nerve is omitted; why the groups of vesicles are so limited. The group of herpes in front of the ear, for instance, may be referred to the twigs of the auriculo-temporal, but why does the whole of the external ear escape, since it gets its supply almost exclusively from this nerve?

In Mr. Tay's patient the eruption was more extensive than in mine, and the temple and adjacent part of the scalp showed vesicles. Some also occurred on the side of the tongue and in the cheek pouch. Possibly in this case the gustatory branch itself was affected. It was remarkable, however, that over the parotid region there were but two small groups, and none, I believe, had ever been noticed on the ear itself.

No. LXXXIII.—*The Genesis of Urticaria  
Pigmentosum.*

There is satisfaction in witnessing the birth of things. A lady who was under treatment for syphilis became much alarmed about an eruption on her infant, and brought him to me. He had been born before his mother contracted the disease, and was in excellent health. His body was covered with urticarious flea-bites. The central puncture was visible in many of them, and there could be no doubt as to the diagnosis.

Two years later I saw this lady again. She told me that her boy had remained in good health, but that he was "still liable to his eruption." She said that it was worse in

summer, but persisted more or less through the winter, and was very liable to come out when he was heated. She added that it was leaving brown stains.

My theory of "*urticaria pigmentosum*" is, that it is a sequel of infantile urticaria caused by fleas and lice. This form of urticaria does not by any means cease with exemption from the exciting causes. The wheals relapse over and over again in connection with other forms of irritation, and the skin remains irritable for long. If the child be of dark complexion, the papules will under such conditions gradually become pigmented.

No. LXXXIV.—*Ringworm and Favus transmutable.*

Willis asserts that ringworm and favus are transmutable. "They are frequently traced from individual to individual, and seem to have the power of engendering one another. I have, for instance, seen *T. lupinosa* arise on the shoulder and arm of a girl fifteen or sixteen years of age, who was in the habit of fondling and nursing her sister, a child of seven or eight, affected with *T. simplex* on the scalp."

It appears to me that there is much clinical evidence in support of Willis's creed. Most of our Atlas have plates which represent conditions exactly like ringworm in conjunction with favus. In spite of the evidence as to differences of specific kind in the cryptogams, I am myself much inclined to suspect that all forms of tinea are transmutable.

No. LXXXV.—*Prevalence of Itch in Scotland in the Last Century.*

In the year 1722, a young lady visiting at a country hall in Scotland, after lamenting that all the male visitors were married, thus expressed herself:—

"However, I live in hope that a loose man may come, though it will be some time first, for all the best families in the parish are laid up with what they call the yoke—which in England is the itch. We have had a noble captain, who dined in a brave pair of white gloves, to my very great surprise; but it was when I was in my London ignorance."

## SYPHILIS.

### No. LXVII.—*Two cases of Gumma of the Parotid.*

I have recently seen two cases in which it seemed that the parotid gland was the seat of syphilitic inflammation. In both, suppuration with some sloughing resulted. The first was in a man named B—, æt. 50, whom I had seen, on account of syphilitic lupus of the forehead and a lumpy syphilitic tongue, on several occasions during 1891-2-3. During this period, under treatment by specifics his lupus was quite cured, and his tongue much improved. In October of 1893, however, he came to me with great enlargement of the right parotid. An abscess had been opened by the surgeon under whose care he was, and much shreddy, sloughy tissue had been discharged. When he came to me there was a sinus leading deep into the mass of induration, from which saliva was freely discharged. A probe passed into the middle of the mass for at least one and a-half inches, but I could not detect any calculus or bare bone.

The enlargement and induration of the gland were such as to suggest the possibility of malignant disease, but this seemed improbable on considering the way the structures had behaved since the incision. The swelling of the gland had been present for at least three months before it was opened, and had been quite painless. The date of the syphilis was many years previously.

A second case, very similar to the above, came under my notice at the Clinical Museum. The patient had been kindly sent to me by Mr. Waren Tay from the London Hospital. The skin over the parotid region had been extensively destroyed, and a granulating surface occupied





## PLATE CXVII.



THIS Plate, taken from a specimen in the Dupuytren Museum, shows the usual position of the periosteal deposits on the parietal bones, known as "Parrot's Bosses." They are characteristic of inherited syphilis.





the position of the gland. It seemed probable that a large part of the gland had sloughed, and there was partial paralysis of the facial nerve. The history was of syphilis eight years before, and of a chronic painless swelling which had ulcerated. The patient was a man of about twenty-eight, who had had but little treatment for his syphilis, and who was at the time of the observation suffering from periostitis of one parietal bone.

No. LXVIII.—*Syphilitic Enlargement of the Mammary Gland in a Man (Chronic Mastitis).*

In connection with the above cases I may mention a remarkable instance of swelling and enlargement of the mammary gland, in a man, in connection with syphilis. In this instance a recent syphilis was of only eighteen months' duration. The left mammary gland became enlarged in all dimensions, hard and painful—it was as large as the half of a small orange; its margins could always be quite easily traced, and no suppuration was ever threatened. In spite of mercurial treatment under which other secondary syphilitic symptoms yielded, the breast remained large for several months. Finally it became reduced to its normal dimensions under iodide of potassium.

It was probable in this case that the patient's syphilis was a second attack. He had been treated for a chancre some years previously. The enlargement of the breast undoubtedly occurred amongst secondary phenomena which were due to a recent infection, but it may still have been due to the old disease, and therefore of the tertiary class. Only one gland was affected, and the difference in results from mercury and iodides was most definite.

No. LXIX.—*Results of the treatment of Syphilis in husband, wife, and child.*

A married man whose wife had borne him four children, who were living, contracted a chancre. It was on the penis, but he throughout persisted that he did not know in the least

how it came there. His wife was at the time more than seven months pregnant. Cohabitation was continued, and the disease was not identified until more than two months later, when the husband was covered with eruption. He consulted Dr. P—— for "a skin disease," apparently in innocence of its real nature. It was, of course, at once diagnosed, and a day or two afterwards he came to me for confirmation. The eruption was abundant, the tonsils were sore, and there was in the free border of the prepuce the parchment remains of a chancre. On the next day he brought to me his wife and infant. The former had an eruption and a sore tongue and throat; the latter, a very fine baby, had only three small ulcers on its scalp. For the husband and wife I prescribed one grain of grey powder three or four times a day, and for the infant inunction of mercury.

I did not see any one of the three patients again until exactly a year had passed, but they had remained under the observation of a well-skilled family surgeon, and in all mercury was continued as first prescribed the whole time. When they were brought to me at the year's end, I found the infant well grown and very fat, and absolutely free from symptoms. The only suspicious feature was a depressed bridge of nose. I was told that it had been by far the best tempered baby of its parents' family, and had thriven better than any previous one. The gums of its upper jaw were swollen and red, probably from the mercury, but possibly only from dentition. It had six good teeth.

The father and mother were in equally good case with the infant. They had not, between them, a single reminder of syphilis, except that there was a bald patch on the woman's tongue. Both had enjoyed excellent health during the treatment, and the man had actually gained four pounds in excess of any former weight.

It may be doubted whether in this instance the infant took the poison in utero from its mother's blood, or acquired it by direct contagion during birth. Its earliest manifestation was three sores on the scalp, and although these never assumed any characteristic conditions, they may have been chancres. They healed as soon as the mercury was begun, and "thrush "

and snuffles, with an eruption on the buttocks, were the only other symptoms. The mother, although she had not mentioned it, was aware at the time of her confinement that she had a sore.

No. LXX.—*Depressions in the Parietal Bones in connection with Syphilis.*

Mr. H. S. A—— has definite depressions in his parietal bones, just like those of the so-called senile atrophy. That on the right side is considerably deeper than that on the left, but there is no doubt that they are symmetrical. I recognised the one on the right two years ago, and made a note. At that time I did not find one on the left, but this may have been because it was then concealed by a sebaceous cyst, which has since been excised.

Mr. A——'s history points clearly to syphilis and to nodes, but not without some peculiarities. He had a chancre in 1884, and took mercury, but nothing whatever followed it until, in 1889, he began to suffer from pains in his bones and joints. At this time he had pain in the right parietal (where the hollow now is), and he himself thought there was swelling, but his surgeon, who often examined it, always denied the swelling. There was, however, no doubt that his right clavicle was swollen, and that there was a lump on the left frontal bone and one on the lower part of sternum.

At the date of my writing these notes (December, 1893) Mr. A—— has no nodes anywhere. His right clavicle is decidedly thicker and larger in all parts than the left. The swellings which were formerly present on the frontal bone and on the sternum have left no traces. He has taken iodide of potassium in month's courses with month's intervals for the last two years. He says that it always relieves him of the "sensations in the bones" and joints. His nodes have never been very painful, but are attended by "pinching sensations," and for these he takes the iodide. He dislikes the latter, as it always depresses him.

[The illustrations which I now introduce are taken from skulls in the Dupuytren Museum, to which I alluded in the

last number of ARCHIVES. In the case described above, the depressions are in precisely the same positions as those shown in the lithographs.

No. LXXI.—*Mental defects in connection with inherited Syphilis—Inability to learn to read.*

Master T—— presents a very peculiar form of mental defect in connection with inherited syphilis. He is an only child. His father died in an asylum, having suffered from general paralysis and fits. During his infancy the boy was extremely ill, and was twice thought to be dead. He took much mercury, the symptoms of inherited syphilis being well marked. He has now a most characteristic set of notched and dwarfed teeth. His head is large, and features rather small. The skin of his face is dry and harsh.

I first saw Master T—— in July, 1887, when he was ten years old, and then recorded the opinion that he was partially idiotic. He had extensive changes in both eyes of that type of choroido-retinitis which simulates retinitis pigmentosa. Both discs were somewhat grey and waxy. He could see well with the left, but only very little with the right. The right eye diverged. I did not detect anything with the ophthalmoscope to explain the difference between the two eyes. He had never had keratitis, nor was he in the least deaf. His head had a girth of 22 inches, and measured  $12\frac{1}{2}$  inches from ear to ear.

I saw the boy again in 1888, and for a third time in 1892. On each of these occasions he seemed to be making progress as regards the development of his mind. He was growing well, and in good general health. I was told that he could remember anything he was told, was interested in many subjects (astronomy, electricity, history, &c.), and fairly well informed; but, remarkable fact, he could not learn to read. Music, as other accomplishments, he learned by the ear. What he was once told he never forgot, but he could not master the art of spelling. He knew his letters, but could not combine them into words.

T—— is now (1894) nearly seventeen years old, and his





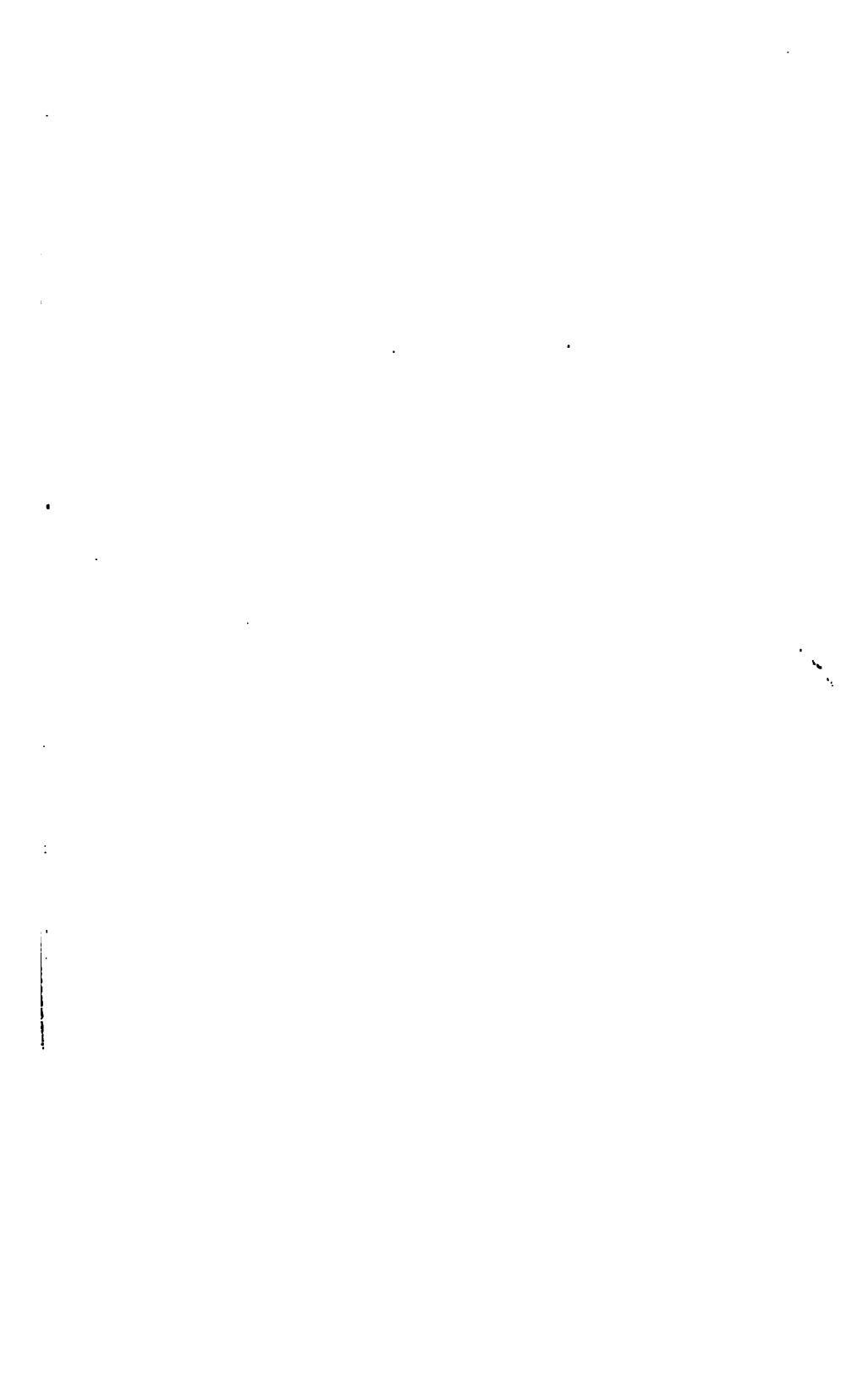


## PLATES CXIII. & CXIV.



THESE two Plates are both from photographs of specimens in the Dupuytren Museum. They illustrate the symmetrical depressions in the parietal bones, which are described at page 228, and again referred to in the accompanying text (page 239).











condition is still that just described. He is good company, and can converse well on any subject; but he cannot learn to read. He is painfully nervous in some matters, and dare not go into certain rooms alone. He is as bashful as regards exposure of his person as a girl, and I have little doubt, from his voice and the downy condition of his face, that his sexual system is but imperfectly developed. He is cheerful, good-tempered in the main, but occasionally obstinate in little things.

It is of importance to note that improvement rather than the reverse is gradually taking place. He can see better than he did, and his intellect improves. He tells me that he still hopes some time to learn to read. From the size and shape of the head, I should judge it probable that he has suffered from hydrocephalus.

This case offers a marked contrast to those which I recorded at page 216 of the present volume. In them we had to deal with a form of aggressive dementia from hereditary syphilis, which had not shown itself until the patient was several years advanced from infancy. In them no severe cerebral symptoms had been present during the infantile or secondary stage of the disease. In them the changes were aggressive. In this case, on the contrary, the symptoms both in brain and eyes were severe in early infancy, and have left their consequences; there is, however, no tendency to aggression, but the reverse. Both as regards sight and brain power, the patient is improving as he gets older.



## THERAPEUTICS AND DIET.

### No. XLIX.—*Chloroform safer than Ether.*

I have for many years been a staunch advocate of ether as the safest anæsthetic. I am beginning, however, to recognise exceptional circumstances. On the authority of Mr. Bernard Pitts, who gives me leave to mention his name, I narrate the following fact. A patient was about to be operated on for strangulated hernia. Chloroform was given, and very alarming syncope resulted. Amongst other measures for resuscitation, the body was held for a time head downwards. The pulse having by this means been restored, the patient was again laid on the table, and the operator was about to proceed when he found that the hernia had gone. Recovery resulted. Had ether been given in this case the event might have been very different.

### No. L.—*Hot Feet from Champagne.*

A gentleman, aged 56, who was distinctly gouty, and who inherited gout, told me that if he drank champagne, it had the effect of making his feet so hot that he was obliged to put them outside the bed in order to get to sleep. His brother was diabetic, and his mother had albuminuria. He had also the curious symptom of liability to a feeling, in a round patch on inner side of one instep, as if he had been scalded. He said that the smarting was most severe, the attacks usually lasting a minute. This patient had the hard, bright, polished nails which I have often observed in the subjects of gout. He had neither sugar nor albumen in his urine.

No. LI.—*On Egg-poisoning.*

The following letter from a distinguished physician is of much interest in reference to idiosyncrasy in respect to eggs. I have written about this repeatedly, for it is a very important item in the knowledge of dietetics. Not a few persons go through life without discovering their susceptibility, and perplex their medical advisers by accounts of the more or less violent gastric attacks to which they are liable. Drugs are prescribed and codes of meals, &c., drawn up, when really all that was wanted was to entirely forbid the use of eggs in all forms of cookery. I have met with many cases in which this simple injunction has cured the patient for life. The experience recorded in the following letter is an exact repetition of that of another medical friend. Both were asthmatics in early life, neither of them can touch honey, both are gouty, and in both the susceptibility to eggs was not present in youth.

“MY DEAR SIR,—I have just read in the current number of the *British Medical Journal* your ‘Example of Egg-poisoning.’ My own personal experience in this matter is curious, and may possibly interest you.

“I am fifty-four years old, and have a ‘good all round’ digestion. For the first twenty years or thereabouts of my life I could eat eggs freely and digest them comfortably. Then, in the course of a few years, they got to disagree with me, so much that, though as fond of them as ever, I had to give them up, and have never since been able to eat a single mouthful of one without suffering great misery. They cause me severe abdominal pain and flatulent distension, which begin about half an hour after the egg has been swallowed, and last till it has passed through the small intestine into the colon; then they cease.

“I accidentally discovered that the offending portion of the egg was the albumen. I can eat any amount of *yolk* with comfort, but a single teaspoonful of the *white* (whether cooked or uncooked) puts me in misery for hours. The only other thing in the whole range of eatables that disagrees with me is honey. This causes exactly the same symptoms as egg albumen, and, oddly enough, my intolerance of honey was acquired just about the same period of life as was my intolerance of egg albumen.

“I have come across several instances of an egg ‘acting like poison.’ In some of them I have proved by experiment that the albumen of the egg was the real offender. I suspect it is so in most cases.

“The only change I can think of as having taken place in my constitution, concurrently with what I have above said, is this: that whereas up

to 20-22 I suffered much from spasmodic asthma, I have since then been quite free from it. I merely mention the fact; whether it has any clinical significance I know not. I have no doubt that I inherit a taint of gout (very slight)."

No. LII.—*Idiosyncrasy as regards Milk as well as Eggs.*

A gentleman, aged 30, who was under my care for syphilis, told me that eggs were a poison to him, always causing a distressing feeling at the epigastrium. A small piece of cake made with egg would cause him great discomfort. Milk, he said, if taken in quantity, had a somewhat similar effect.

I can support this patient's statement as regards milk by the experience of another observer who cannot take eggs, and in whom also large quantities of milk always disagree in a similar though much less marked degree.

No. LIII.—*Lupus Sebaceous in numerous small scattered patches on head, neck, and shoulders—Strong family history of tuberculosis—Patient deeply pigmented as a consequence of a long course of Arsenic—Dry soles and palms—Senile black freckles, largest on right side.*

Mrs. M——, æt. 40, the wife of a clergyman of phthisical family, and herself the subject of delicate lungs, came to me for a somewhat peculiar form of lupus erythematosus. She had a number of quite separate patches on the face, shoulders, and chest. There were symmetrical patches under and behind the ears, one on right temple, one on the scalp, three or four in the clavicular regions, and two large ones in the middle of the back. The eruption was believed to have begun on the face, about three years ago, by what was then called acne on the cheeks and nose. There was nothing, when she came to me (January 3, 1894), to be identified as lupus in these parts, but the nose was somewhat red and rough.

When Mrs. M—— consulted me she had been taking arsenic in four-minim doses for more than a year. Her skin

is everywhere very dark, her heels are cracked and sore, and the palms and soles very dry. "Often there are a lot of little pimples along the sides of my feet, which burn and itch." On her face there are black freckles, on the eyelids especially, abundant and large on the right side. Her mother's family is very consumptive. She herself suffered much from chilblains. Her mother lost nearly all her brothers and sisters from consumption. Her eyes have been irritable all the summer, often bloodshot, and she feels as if she could not open them.

For five months, whilst treated by arsenic, she has had a constant cold in the head. Nothing moves it. She has sneezing and nose running, and often sits up in the night sneezing.

Mrs. M—— was a florid, energetic lady, rather thin, but not out of health, excepting habitual catarrh and dry cough. I cauterised many of the patches with nitric acid, and advised her surgeon (Mr. H——, of H——) to touch the others.

#### No. LIV.—*Intolerance of Light in Children.*

I have found a combination of belladonna and bark with small doses of opium very efficacious in cases of intolerance of light in children. The following is a prescription which agreed well in the case of a girl of thirteen, in whom a slight attack of pustular ophthalmia intolerance, without obvious local cause, had persisted for a long time. Three minims of Nepenthe, ten of Liquor Cinchonæ, and a sixth of a grain of extract of Belladonna. This was taken three times a day regularly for five weeks, at the end of which time the patient came to me again entirely free from her trouble, and in much improved health. It is needless to say that local treatment must be used if pustules, ulcers, or granular lids are present.

#### No. LV.—*Iodides disagreeing.*

Mr. S——, 36, who has taken iodides on and off for some years, says that they always make him feel cold. He has

also some catarrh when he takes them, but his chief discomfort is constant chilliness.

Dr. G—— complains that iodides make his legs ache and swell.

The following were the expressions used by a patient who had had considerable experience of the iodide:—"Iodide of potassium seems to work very strongly on me; it is awful stuff. It depresses me, and almost deadens my brain."

No. LVI.—*The Small-dose Suppression Treatment of Syphilis.*

One of the advantages of the small-dose treatment of syphilis is that it does not entail any interruption of the patient's avocations.

A sea-captain, aged 53, who was, as he said, the surgeon to his own ship, consulted me on account of a chancre close to the meatus. It had been present two months, and he had a papular eruption and hard glands. I prescribed one grain of grey powder to be taken six times a day with a tenth of a grain of opium. I did not see him again for three months, and meanwhile he had been a voyage, and had been much exposed to weather. When he returned to me he was in excellent health, and wholly free from symptoms. He reported that he had, with the exception of two or three weeks at one time when they had been omitted on account of inter-current illness, taken the pills quite regularly. Although he had sometimes in bad weather been fifty hours on the bridge he had borne the mercury well, and had gained flesh. His report was, "My tongue has been cleaner and my digestion better than ever in my life before. I used often, when at sea, to suffer from constipation and to feel bilious, but I have had nothing of that the last two months."

No. LVII.—*Physiological effects of Arsenic.*

A young gentleman consulted me for a troublesome and severe form of palmar and plantar psoriasis. He had already had much treatment, and I was very desirous to cure him.

Arsenic in nine-minim doses three times a day was ordered in combination with a sixteenth of a grain of tartarised antimony. He took these doses for a fortnight without the slightest inconvenience, and with the utmost benefit to the affected parts. Suddenly, at the end of that time, the palms and soles, nearly well of the eruption, became exceedingly tender. He complained that they felt hot and smarted. On leaving off the arsenic this condition disappeared.

No. LVIII.—*Selections from Dr. Mead.*

The following quotations from Dr. Mead's writings are, I think, of some permanent interest :—

“Dr. Robert Whytt, of Edinburgh, repeated the experiments (dissolving calculi) with lime-water made with oyster-shells and cockle-shells well calcined, by pouring seven or eight pints of water on one pound of the fresh calcined shells. The experiments succeeded with both sorts ; but he soon found that the oyster and cockle-shell lime-water possessed a much greater power of dissolving the calculus than that of stone-lime. Then he proposes the method of drinking the shell lime-water, the quantity of which may amount gradually to four pints every day for adults, and for children less in proportion ; and he concludes with instances of the happy effects of this method.”

“Mead is likewise a proper drink ; for honey is an excellent diuretic. A spoonful also of honey in a glass or two of the infusion of marshmallow roots is an admirable cleanser of the kidneys, if used for a constancy. The wines ought to be the softest and smoothest that can be had ; and the lightest, clearest river or running water is preferable to all other. For, as Pliny says, those springs are particularly condemned the waters of which line the vessels, in which they are boiled, with thick crusts.”—Nat. Hist. Lib. xxxi. cap. 3.

“Another remarkable circumstance is, that immoderate joy, too long continued, as effectually disorders the mind as anxiety and grief. . . .

"I have formerly heard Dr. Hale, physician to Bethlem-hospital, and of great experience in these matters, say more than once, that in the year MDCCXX, ever memorable for the iniquitous south-sea scheme, he had more patients committed to his care, whose heads were turned by the immense riches which fortune had suddenly thrown in their way, than of those who had been completely ruined by that abominable bubble. Such is the force of insatiable avarice in destroying the rational faculties!"

This observation may be recalled to mind with some comfort in the year MDCCCXCIV.

No. LIX.—*The Tannate of Mercury.*

I am not fond of trying new drugs for purposes which old ones seem to serve efficiently. My favourite preparation of mercury, for internal use, has long been the grey powder. On the recommendation of a medical friend I have recently tried the tannate, a salt which I was assured was free from the inconvenience of causing diarrhoea, which it must be admitted grey powder not unfrequently does. I prescribed the tannate without opium, and was disappointed to find that it purged every patient who took it. Opium in combination appears to be just as necessary as in the case of grey powder. I have therefore returned to the latter, and shall probably never prescribe the tannate again, as it appears to possess no single advantage. Multiplicity of remedies for the same purpose is an evil, especially when one has a definite superiority to the others. It causes waste of time and thought, and interferes with uniformity of observation. Habitual simplicity of prescription has the great advantage of leaving the mind and memory free to attend better to the clinical peculiarities of the case.

## CATECHISM OF SURGERY.

No. CLXXXIV. — *Memoranda in reference to the study of Diseases of the Skin.*

We must study causes rather than names. In other words, we must try to get a clear conception of the morbid process, its cause, nature, and course, and not content ourselves with a knowledge of its conventional name.

If any names in ordinary use comprise a knowledge of cause and course, let us take them thankfully; their employment in future will save us much trouble, but all names must be clearly defined.

We must remember that many diseases of the skin which have got different names are yet not by any means wholly distinct. They often join each other. Between many of the groups there are definite connecting links.

If an eruption is general, but not accurately symmetrical, it is very probably due to a local cause (scabies, pediculi, contagion of cryptogams, contagion of pus, &c.).

If an eruption is definitely and constantly non-symmetrical, it is either a neurosis or due to a local cause.

If an eruption which is constantly non-symmetrical is arranged on plan, *i.e.* in definite regions, it is probably due to nerve-influence. If it is quite irregular, it is due to a local cause.

When an eruption shows a definite tendency to symmetry, is persistent or tends to speedy relapse after apparent cure, it is probably allied to the Psoriasis group.



We must not judge of symmetry or non-symmetry by a single case, but collect several cases of the same kind.

When a symmetrical eruption goes through short and definite stages and disappears spontaneously, it is an *Exanthem*.

All eruptions which are constantly and definitely benefited by arsenic, but which are difficult to cure and tend to relapse, are probably related to psoriasis.

If an eruption consists of little hard red spots which are formed at the mouths of hair follicles, and do not tend to suppurate, it is a *Lichen*. We must remember, however, that the word thus used has a pathological rather than a clinical meaning.

If an eruption consists of red spots which tend slowly to suppurate, and which occur by preference on the face and shoulders, it is an *Acne*.

If an eruption affect the parts where large hairs grow, is attended by suppuration at their roots and causes their fall, it is a *Sycosis*.

If an eruption affect the hands and feet, with possibly nose and ears, and is always worse in cold weather and better in summer, it belongs to the *Chilblain* group.

Syphilis may simulate almost every form of skin disease which can be named, and has no types of eruption which are peculiar to itself. We have syphilitic lichen, acne, psoriasis, pemphigus, roseola, lupus, and many more.

If a patch of eruption spreads gradually at its edge, and shows a tendency to heal in the middle, leaving more or less of scar, it is, with a few exceptions, either lupus or syphilitic lupus.

Always remember that you have to do not alone with the special cause of the eruption, but with the peculiarities as regards tissue-health of the individual on whom the cause acts.

If an eruption affects chiefly the face and the backs of the hands, and is worse in sunny weather, it belongs to the group of sun-blains, or summer eruptions.

The first primary division of skin diseases is into two classes—1st, those due to causes acting externally; and 2nd, those due to causes acting from within.

We must remember, however, that in those caused most definitely by external causes, such as scabies and ringworm, the state of the patient's tissues will much modify the result.

Diseases caused by the state of the blood usually display bilateral symmetry.

Diseases caused by nerves usually display conspicuous deviations from bilateral symmetry.

An eruption which is definitely one-sided, of short duration, and spontaneously curable, is probably, whether vesicular or papular, of the nature of Zoster.

The term Herpetiform may be conveniently applied to all eruptions which are arranged in corymbiform streaks on the pattern of zoster.

The patches of morphea are often arranged exactly like those of zoster, and the same is true of certain forms of ichthyosis in streaks. These may suitably be spoken of as "herpetiform."

With the exception of the neuritic group, most forms of inflammation of the skin are attended by the development of contagious elements, and in virtue of their existence tend to spread.

A knowledge of the fact that most forms of dermatitis are more or less contagious (to the patient), gives the clue to successful treatment.

Many so-called "diseases" are due to congenital defect in the organisation of the skin.

Some congenital defects in the formation of the skin are obvious at birth, but many are only revealed when the skin is exposed to air and sun, or in connection with advance in age.

If a peculiar disease affects several members of the same family, we may be sure that it is due to defective organisation.

Some defects in organisation are attended by structural peculiarities (*e.g.*, ichthyosis), whilst others entail rather liabilities to disturbance of function.

It is a mistake to use such names as "urticaria" and "eczema" as if they denoted diseases which are in themselves clinical entities.

The names just quoted, and many others, belong to forms of dermatitis to which almost all persons are more or less liable, and about which there is nothing whatever specific.

Because a man has an irritable skin, and is in the habit of scratching it, we ought not to say that he has got the disease "prurigo"; or if for convenience we use that name, it should be with a clear mental conception of what we mean by it.

Great restriction of thought results from the premature employment of substantive names.

It is safer in order to clearness of thought to say that a man has a pruriginous skin, that he is prone to urticarious irritation, or that his skin readily becomes eczematous, than to say that he has "prurigo," "urticaria," or "eczema."

#### No. CLXXXV.—*Euphoria.*

*Question.* What is the meaning of the word Euphoria?

*Answer.* According to Power and Sedgwick (*vide* New Sydenham Society's Lexicon) it is "a word used to express well-being, or the perfect ease and comfort of healthy

persons, especially when the sensation occurs to a sick person." Although classical, it has for long been almost disused (at any rate, in London).

Q. Is it likely to be again employed ?

A. It is said to have found favour in connection with the Opium Commission, as expressing better than any other the real motive of the opium consumer.

Q. Then it is not synonymous with good health ?

A. No, not exactly. It means the sense of bodily comfort which may not always be present in states of sound organic health, and which may be attained sometimes in spite of its absence.

Q. Then it is possible to obtain euphoria by means which do not necessarily conduce to health ?

A. Yes, certainly. It may be only a temporary attainment, and may be followed by ill consequences.

Q. In a general way, may it be held that the agents which secure euphoria conduce to health ?

A. Probably it may, for a state of comfort and absence of pain is conducive to healthy nutrition, and the reverse.

Q. But we are not to regard them as food stuffs ?

A. No, not exactly such, though it is impossible in any case to deny them that position. We do not know but what theine and caffeine may be used for the direct nutriment of brain cells. Sydney Smith asserted that a man's intellect depended upon the quantity of coffee that he drank, and he may have been right in regarding it as a brain-feeder. Probably, however, these agents have other and more immediate influence.

Q. You count, then, tea and coffee as agents conducive to euphoria ?

A. Yes ; our motive for taking them is in the main the wish to secure the sense of comfort which we know will follow. We take them without feeling sure they will feed us.

Q. But do we not take food from the same instinctive feeling ; and does not the very plainest food often conduce to euphoria ?

A. Unquestionably. In each instance it is appetite, or longing, which leads us.

No. CLXXXVI.—*The Parasites of Malaria.*

Q. What is the relation of the malaria parasite to the blood corpuscles ?

A. It is developed in the interior of the red corpuscles.

Q. What is the nature of the parasite zoologically ?

A. An amœba.

Q. Does the parasite ever become free ?

A. Yes ; by rupture of the containing blood cell its spores may become free.

Q. What is the action of quinine upon the parasite ?

A. It kills it.

Q. At what stage are spores formed ?

A. At a late period of growth, when the amœba is ripe for multiplication.

Q. Can free spores be recognised in the blood ?

A. Yes ; in certain malignant forms of malaria, free spores, around masses of pigment, may be found.

Q. What appearances are presented in the earliest stages ?

A. A pale or whitish body, crescentic, round or branched, is seen in the blood corpuscle.

Q. What is the next stage ?

A. The body increases in size, becomes more irregular in form, and acquires pigment granules.

Q. What are the final stages ?

A. The parasite fills the blood cell, develops (by fission) spores, which are often arranged symmetrically in a wheel-like pattern. It may lastly become free, and undergo pigmentary degeneration.

Q. Under what conditions are flagella developed ?

A. The parasite, when free, occasionally throws out flagella.

Q. Can the parasite be cultivated ?

A. No success has as yet attended the attempt.

Q. Can it be transferred from human blood to that of animals ?

A. Apparently not.

Q. Can it be transferred from man to man ?

A. Yes, but many experiments have failed. Success depends upon the age of the parasite.

Q. What is the pathology of "malaria comatosa"?

A. The blood cells in the pia mater are crowded with parasites, and sometimes many of the latter are found in a free state.

Q. What is the conjectural association of the parasite with the rigors of malarial fever?

A. It is supposed that each rigor denotes a reproductive stage in the parasites.

Q. Are the parasites of the quotidian, tertian, and quartan types of malarial fever specifically distinct?

A. It is as yet somewhat doubtful. Unquestionably they develop into different forms, and the diagnosis may often be made by the microscope.

Q. What are the chief differences between the tertian and quartan parasites?

A. The spore formations in the quartan are larger and arranged with more symmetry. Other differences concern size and pigmentation.

Q. What becomes of the young spores after they are free?

A. They attach themselves to blood corpuscles and pass into their interior.

Q. In what part of the parasite is the pigment first formed?

A. In the periphery; but when segmentation is approaching it collects in the centre.

#### No. CLXXXVII.—*Vaccination.*

Q. What is meant by a foveated vaccination scar?

A. The term foveated is used in contrast with that of plain and unpitted, and denotes the condition of pitting and of radiation of lines of scar from a central point. The margin of a foveated scar is usually more or less notched.

Q. If a pregnant woman suffer from small-pox, will her infant be susceptible of vaccination?

A. If a pregnant woman suffer from small-pox at any considerable period before her delivery (say more than two weeks), it is probable that her infant will be rendered

insusceptible of vaccination. If, however, only a few days have elapsed, then the vaccination of the infant on birth will run its normal course.

No. CLXXXVIII.—*Paralysis of the Portio Dura.*

Q. What is "Bell's paralysis?"

A. Paralysis of the portio-dura muscles, in consequence of some affection of its trunk during the passage through the temporal bone.

Q. In what does Bell's paralysis differ from facial paralysis from cerebral causes?

A. All the facial muscles are involved, whereas in the cerebral cases the paralysis is never complete as regards the orbicularis of the eye and the occipito-frontalis.

Q. In cases of hemiplegia from cerebral disease, is the seventh-nerve usually affected?

A. Yes; but the muscles it supplies fail only slightly and partially.

Q. Is the paralysis of the face on the same side as that of the limbs, and on that opposite to the lesion?

A. Yes.

Q. How would you explain a case in which, after a fall on the head (see Watson's Lectures, vol. i., page 502), a patient had paralysis of the limbs on one side and facial paralysis on the other?

A. It is probable that an injury to the brain had been received on the side opposite to the hemiplegia of the limbs, and a fracture of the temporal bone on the same side as the paralysis of the face.

Q. What symptoms would you look for in corroboration of such a diagnosis?

A. The patient would probably be deaf on the side on which his face was paralysed, and there would be probably found, if carefully searched for, some slight defect in the muscles of the face on the same side as the hemiplegia.

Q. Would there be any other fact which might assist the diagnosis?

A. It is very probable that there might have been bleeding

from the ear on the side on which the facial paralysis was present.

Q. In Bell's paralysis are all the muscles supplied by the facial involved?

A. No; for certain twigs are given off from the nerve before it enters the auditory canal, and these would escape.

Q. If a distinguished author on the science and practice of medicine has written respecting hemiplegia that "The facial or portio-dura nerve is not generally touched by the paralyzing lesion," does he make an error?

A. Yes, undoubtedly, for it is always more or less involved.

Q. If the same author adds to his statement, "It is the fifth-nerve which is generally involved more or less in hemiplegia," does he in any sense correct his error?

A. No; for he appears to think that the fifth gives motor-fibres to the face, which is not the fact.

Q. How about the buccinator?

A. The fifth gives only sensory branches to this muscle. It is the facial which gives it motor power.

Q. How do you prove that?

A. By observing the baggy condition of the cheek in cases of Bell's paralysis.

Q. What, then, has the fifth-nerve to do with the muscles of the face?

A. Nothing whatever as to motion. It supplies only the deeper muscles of mastication,—the temporal, masseter, and the pterygoids.

Q. Is the statement just quoted, that the fifth-nerve is implicated in cerebral hemiplegia, correct?

A. Very probably it may be, but the defects in the muscles which it supplies are not conspicuous, nor in many cases easily appreciated even when they are searched for.

Q. How would you search for them?

A. By placing the fingers over the temporal and masseter regions, and then telling the patient to clench his jaws. In most cases of cerebral disease it is difficult to avoid error in this trial.

Q. You spoke just now of paralysis of the palate. What symptoms denote that condition, and how would you test it?



A. The uvula is very usually curved towards the sound side, and the arch of the palate is ill-marked on the paralysed one. On making the patient say "Ah," there is no movement on the paralysed side, but a dimple forms in the other.

Q. Are any other cranial nerves besides the portio dura and the fifth commonly involved in cerebral hemiplegia?

A. The upper nerves, the olfactory, optic, motor nerves of eye-ball and auditory usually escape. But the motor nerves of the tongue and pharynx are often more or less involved.

Q. How would you recognise paralysis of the muscles of the tongue?

A. The tongue when extruded will be slightly pointed to one side (the paralysed), being pushed over by the muscles remaining sound.

Q. Would the paralysed side of the tongue be the same as that of the hemiplegic limbs?

A. Yes.

Q. Is it, then, true that in cerebral hemiplegia all the motor lesions, whether from cranial or spinal nerves, will be crossed; that is, be on the opposite side to the disease of the brain?

A. Yes, undoubtedly. All exceptions, or apparent exceptions, to this rule will require special explanation.

#### No. CLXXXIX.—*The Treatment of Strangulated Hernia.*

Q. What do you consider the chief cause of danger in strangulated hernia?

A. The damage which the gut receives from the strangulation. This may act immediately by causing shock, or, secondarily, by local changes.

Q. What ought to be the main object in treatment?

A. To relieve the strangulation as promptly as possible. Let there be no delay.

Q. Does not the hope of succeeding by the taxis often cause delay?

A. Undoubtedly. The patient hopes and his surgeon hopes, and thus often delay occurs.

Q. Is not this an argument against the taxis?

A. Not the least, for the judicious surgeon on failing with the taxis will proceed at once to the operation. Neither he nor the method he advocates are responsible for the delays of others.

Q. With whom do you consider the responsibility chiefly rests for the delays which all acknowledge and all lament?

A. I fear it must be recognised that it rests largely with the family-surgeon who first sees the case, and who, but too often, underrates the importance of the early symptoms and the danger which attends the case. It rests also partly with the patient, who does the same, and who not unfrequently refuses a consultation which he suspects will lead to an operation.

Q. You do not then give any share of the blame to the consultants?

A. I do not suppose that any delay ever takes place after once a consultant has seen the patient, unless it be from the patient's obstinacy. For several generations all hospital surgeons have fully recognised the absolute necessity for prompt measures.

Q. You attach much importance to the patient's dread of an operation?

A. I do. Many a patient will refuse to submit to an operation who would gladly take an anæsthetic if he thought that his rupture would then be reduced without cutting. It is possible that he may have had it down before and got it back after a little waiting, and he hopes for a like result again.

Q. Do you suspect, then, that the urgent recommendation of immediate operations which prevails at the present day has a deterrent influence upon patients, and thus causes delay?

A. I think it very possible. If a family surgeon says to his hernia-patient, "You must go into the hospital, and they will put it back for you," the patient goes at once; but if he says, "You must go and have an operation," but too often he is met with a refusal.

Q. What are the terms in which you advise patients under such circumstances?

A. I first make up my mind as to whether the case is

unsuited for the taxis, and if it be not, I usually make a brief trial without an anæsthetic. If unsuccessful I then say, "You see that I cannot get it back, but if you will be put under chloroform I shall then, in all probability, succeed. You must understand, however, that if I don't succeed an operation will be absolutely necessary, and I must have your permission to go on with it at once." I am entitled to speak to my patient with much confidence as regards the taxis because I always take great pains with it, and very usually do succeed.

Q. Do you meet with many cases which you regard as unsuited for the taxis?

A. Really, but very few. Certainly in nine out of ten, and I should think a much larger proportion, I give it a patient trial.

Q. If an operation is needed, do you endeavour to avoid opening the sac?

A. I regard all cases which I have thought suitable for the taxis as being also those in which it is better to avoid opening the sac.

Q. But if you do not open the sac I presume you do not attempt radical cure?

A. You must understand that what I am saying refers chiefly to my practice of ten or twenty years ago. The proceedings for radical cure, which I believe to be distinctly improvements, have come into use since my hernia days. I have been eight years out of hospital work, and my practice in hernia cases which was once large has diminished to a small one. In spite, however, of the benefits of radical cure I still prefer to operate in cases of strangulation without opening the sac, and to leave that triumph to a more suitable time.

Q. What do you mean by a more suitable time?

A. I mean one when the serous membranes are not in an inflamed state. I cannot help a suspicion that it is much more dangerous to expose inflamed intestine, or an inflamed sac, to the air than to operate for radical cure when the parts are healthy. To that I attribute the undeniable fact that hernia-operators in the present day seem unable to reduce their percentages of fatality, whilst operations for radical cure are done with but little risk.

Q. Do you suppose that the modern practice of removal of the sac, with a view to radical cure, has conduced to an increase of fatality in operations for strangulated hernia of late years?

A. I see no reason to suspect it; but I am sorry to observe that it does not appear to have done much to diminish it.

Q. You believe, then, that the exposure of sac and intestine in an inflamed state to the air is in itself a source of increased danger?

A. I am forced to that conclusion by observing that scarcely any patients die after successful taxis, whilst many in precisely similar conditions, like duration of strangulation, &c., do so after operations.

Q. But is not that an argument in favour of early operations, before the bowel is inflamed? Do you think that there would be danger of that kind if operations were done within six or even twelve hours of strangulation?

A. Understand me, the protest against delay in strangulated hernia is one which every hospital surgeon for the last half century has upheld. I claim that no one was more zealous in it than myself during the years that I taught surgery. The plea for the taxis is not an advocacy of delay. On the contrary, it will lead, I contend, to the avoidance of delay. If you hope to have the chance of operating in most cases of strangulated hernia within twelve or twenty-four hours, you are hoping for what you will never get. The more strongly you advise the operation, the more will such cases elude you. Besides, a man dexterous in taxis will never need to operate at all if he can see his cases as early as that.

Q. What are the conditions which would lead you to decline the taxis altogether?

A. The duration of strangulation, if the symptoms have been urgent, will count for something. I should, however, be guided chiefly by the state of the patient and the state of the hernial tumour. If the patient were low and ill, I should like to see the intestine, and so also if the parts surrounding the sac were otherwise than quite free from cedematous swelling.

Q. Do you ever see bad cases in private practice?

A. The worst cases which I have seen have been in

private. In one case the patient died, with an unrelieved strangulated femoral hernia, just before I got to the house. In another the sac and skin had given way, and a faecal fistula was already formed. In a third, very recently, I was taken into Jermyn Street to see a wealthy gentleman moribund with a gangrenous inguinal hernia. This patient lived almost within stone's throw of half the hospital surgeons of the metropolis, but he had resisted all recommendations of further advice in the fear that an operation would result.

Q. Probably in this last instance the taxis had been abused ?

A. No, indeed it had not. The surgeon in attendance had almost wholly contented himself by repeatedly advising a consultation. We must deal with human nature as it is, and adapt our measures to the prejudices and misconceptions of our patients. It is not possible to enact that all hernia patients shall come under the care of specially skilled surgeons within twelve hours.

Q. You think that the old practice as regards the taxis conduced better to the end in view than the present strenuous advocacy of operations ?

A. Most distinctly I do. Let the public and the family practitioner understand that the consultant will probably succeed without operation, and the chances of an early consultation become much increased.

Q. I believe that you advocate attempts at taxis in cases of abdominal obstruction in which there is no external hernia ?

A. I do. My rule of practice is the same in both classes of cases, and it is as promptly as possible to put the patient under an anæsthetic and attempt by manipulations, &c., to effect taxis. If the attempt fails, then operate at once. In neither case is the taxis to be regarded as a substitute for the operation ; but in both it should be fairly tried first and at as early a period as possible.

Q. Do you then advise abdominal taxis in all cases of abdominal obstruction ?

A. Invariably. It ought to be the first operative measure thought of as soon as such a diagnosis is made. If done promptly and efficiently I believe that in a large majority of cases nothing further would be required.

No. CXC.—*On the Treatment of Persons Drowned.*

Q. In the case of a drowned person is it good practice to lift the body by the legs in order to "let the water run out?"

A. Yes; provided it can be done easily and with gentleness.

Q. Is it true that water really enters the lungs?

A. Yes; the old notion that spasm of the glottis always prevents the entrance of water is a fallacy. The presence of water in the air passages is indeed one of the main causes of danger to persons who have been taken out of the water still alive.

Q. Are there then any reasons why systematic inversion of the body should not be practised in all cases?

A. If it be roughly or awkwardly done, or if efficient help be not at hand to do it quickly, it may become in itself dangerous. When the heart is but just beating anything like rough usage may easily stop it.

Q. What other means may be taken to facilitate the escape of the water?

A. The body may be placed for a short time face downwards with the head dependent.

Q. What is the best position after this has been done?

A. On one side, with the chest supported and the head low. This will allow fluid to trickle out and will also empty the lung which is uppermost.

Q. Is there a grave objection to artificial respiration (Sylvester or other) in the dorsal position?

A. Yes; it may pump the fluid backwards and forwards in the larger tubes, promote the secretion of mucus and, by sucking it deeper in, still further clog the air-cells.\*

Q. Is the supine position in itself bad?

A. On the back it is impossible for fluid in the pharynx to escape. Fluid regurgitated from the stomach may also easily be sucked into the lungs. It is a very dangerous position, as has been so well taught us by Dr. Bowles.

\* I have written these answers after a conversation with Dr. Bowles, whose opinions for the most part they express. See his paper in *Medico-Chirurgical Transactions*, Vol. 92.

Q. Is artificial respiration of great importance in these cases?

A. If the breathing have really stopped, it is essential, but not otherwise. If the patient be breathing ever so feebly, it is best to put him in a proper position, and then wait and watch. That position should be on one side.

Q. What is the best method of artificial respiration in such cases?

A. The "Marshall Hall" method.

Q. How is it done?

A. The body is turned, fifteen times in the minute, from face to side, and whilst on the face pressure is made on the spine.

Q. Ought there to be any change from one side to the other?

A. On no account. If one side be kept to, the fluid gravitates into the lower lung and leaves the other free for respiration. This advantage would be at once lost if the sides were changed.

Q. Has the side position any other advantages?

A. Yes; it allows the tongue to fall forwards, and thus prevents a form of choking which is very common if the patient be supine.

Q. You hold, then, that the injunction *ne quid nimis* applies to some extent to the treatment of the drowned.

A. Certainly. It is easy to do harm when aiming to do good. Artificial respiration with the patient on his back is usually hurtful, and may take away the chance of life. The case is very different from one of suffocation without fluid or of chloroform poisoning. In the latter, artificial respiration has no drawbacks.

Q. What other measures for resuscitation are to be adopted?

A. They will depend very much upon the temperature of the water to which the body has been exposed. It may be very important to restore warmth by clothing and frictions. In all cases it is desirable by rubbing the limbs to favour the return of circulation in them.

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## A CHRONOLOGY OF MEDICINE.

### “ SPACE-FOR-TIME ” ARRANGEMENT.

THE present portion of a Chronology of Medicine is issued in proof form, in the hope that some of my readers may be able and willing to supply me with corrections and additions. It has been somewhat hurriedly compiled, and, in the first instance, simply for my own use. It is susceptible of great extension and improvement. When so improved it will, I believe, be found to be a very convenient synopsis of the chief events in the history of our art. It will be seen that it is arranged on what I have called the space-for-time method. Each event is placed, so far as could be arranged, at its proper distance as regards time from those which preceded it. This method, which I have long used for date tables, case-taking, &c., has great conveniences. It facilitates the acquisition of a clear view of the mutual relation, in point of time, of different events, and obviates the necessity of constantly making calculations. It has also the great recommendation of enabling the reader at any time to supply in writing any additional details which he may think worthy of insertion. These can at once be put into their proper place.

I purpose to publish the Chronology, when corrected, as part of my next ARCHIVES; and may probably, at the same time, send out proof slips (arranged on a similar plan) for the earlier centuries, or at any rate for the Græco-Roman period. Any emendations, or suggestions, which my readers can give, will be gratefully received.





# PROOF.

## A CHRONOLOGICAL

Dates.	The FIFTEENTH CENTURY (f)
1400	<p>Attempts at the revival of the study of human anatomy had been made in</p> <p>Great plague in London, 1407.</p> <p>The dancing mania occurred at Aix-la-Chapelle and at Strasburg.</p> <p>The University of Oxford was in high repute. Anatomy especially cultivated</p>
1450	<p>Leonardo da Vinci born, 1452 ; died, 1519 (chemist, botanist, anatomist, and</p> <p>Linacre born, 1460.</p> <p>Mathew de Gradibus published works on anatomy. He first correctly descri</p> <p>Brissot born, 1478. He practised in Paris, but would not visit patients when</p> <p>Fracastorius, 1482 ; poet and physician. He wrote a poem on the venereal d</p> <p>Linacre elected Fellow of All Souls, 1484.</p> <p>Quarantine for the plague said to have been first employed about this time (l</p> <p>Syphilis attracted much attention in Italy, France, and Spain.</p> <p>Fallopious born, 1490, Modena ; died, 1563.</p> <p>Sir Thomas Elyot born ; date uncertain.</p> <p>Paracelsus born, 1493.</p>
1499	

## MEDICINE.

1499).	Contemporary Events.
<p>during the preceding century (Salerno, Venice, [and Bologna).</p> <p>college.</p>	<p>Henry V., 1413.</p> <p>Henry VI., 1422.</p> <p>Joan of Arc burned, 1431.</p> <p>Columbus born, 1435.</p>
<p>s.</p> <p>in cash.</p> <p>ns).</p>	<p>Reuchlin born, 1455.</p> <p>Wars of the Roses.</p> <p>The Turks took Constantinople.</p> <p>Edward IV. proclaimed, 1461.</p> <p>Luther born, 1483.</p> <p>Louis XI. died, 1483.</p> <p>Edward V. } 1483.</p> <p>Richard III. }</p> <p>Battle of Bosworth, 1485. Sweat- ing sickness.</p> <p>Henry VII.</p> <p>Discovery of America.</p>





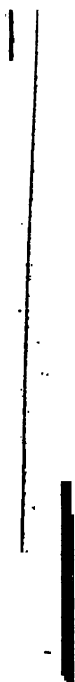


## A CHRONOLOGY

Dates.	The SIXTEENTH CENTURY (from 144
1500	<p>Jerom Cardan born, 1501, at Pavia ; died in Rome, 1575 ; wrote extraordinary record Fernelius, a most distinguished physician in Paris. Physician to Francis I. and Her</p> <p>Thomas Gale born, 1507 ; <i>Encheiridion of Surgery</i>, 1563.</p> <p>John Kay (Caius) born in Norwich, 1510.</p> <p>Servetus born, 1511 (burned at Geneva, 1553). The first <i>Pharmacopœia</i> publishe</p> <p>Vesalius born, 1514, a Fleming.</p> <p>Berenger of Carpi flourished at Bologna. He dissected more than 100 bodies.</p> <p>Ambrose Paré born, 1517.</p> <p>Veites, a Hamburg doctor, burned for practising midwifery.</p> <p>Aldrovandus born, 1522. Brissot died, 1522 ; he had written on bleeding in pleurisy, Linacre founded " <i>Physic Lectures</i> " at Oxford and at Cambridge.</p> <p>Paracelsus, Professor in University of Basle, 1526 ; nicknamed " <i>Alter Luther</i>."</p> <p>Sir William Butts admitted member of College of Physicians ; a friend of Cranmer a Sylvius taught anatomy in Paris. Vesalius put together a skeleton, 1530.</p> <p>Paolo Sarpi, " <i>Father Paul</i>," 1532. He discovered the valves of the veins.</p> <p>William Butler born at Ipswich, 1535 ; practised at Cambridge, but visited London a Andrew Borde (Andreas Perforatus), degree at Montpellier and Oxford ; a Carthus</p> <p>William Gilbert born, 1540, Colchester.</p> <p>Paracelsus died, 1541. Sir Thomas Elyot published ' <i>The Castell of Health</i>.'</p> <p>Hery, after battle of Pavia, devoted his time to the inunction treatment of syphilis.</p> <p>Casseriis born, 1545, Padua. Dr. Butts died, 1545.</p> <p>Bethlehem Hospital founded, 1547.</p>
1550	<p>Francis Anthony born, 1550, a charlatan chemist-physician ; sold " <i>aurum potable</i> "</p> <p>Caius came to London, 1551. St. Thomas' Hospital founded, 1552.</p> <p>Prospero Alpini born, 1553 (Venice). Thomas Vicary, Master of St. Bartholomew's William Cuninghame practised in Norwich, 1556, and London ; lectured at Surgeon's H</p> <p>Colot practised lithotomy in Paris, under patronage of Louis XI. Dr. William Bulle</p> <p>Hildanus born (Berne), 1560. Gratarolus died, æt. 52, wrote on the sweating sickness</p> <p>Bacon born, 1561. Walter Bailey appointed Queen's Professor of Physic in Oxford</p> <p>Fallopious died, 1563. [diseases and brewing.]</p> <p>Dr. Gaynes cited before the College of Physicians for impugning the authority of Ga</p> <p>Dr. Thomas Penny practised in London, a " <i>Second Dioscorides</i>."</p> <p>John Banister took his degree, 1573, practised in Nottingham, and wrote much on su</p> <p>Caius died, 1573 ; he had been physician in succession to Edward, Mary, and Elizab</p> <p>Van Helmont born, 1577, Brussels (an anti-Galenist).</p> <p>Harvey born, 1578, at Folkestone.</p> <p>Rousset wrote on the Cæsarian operation. Felix Platter advocated reform in the tree</p> <p>Edinburgh College of Physicians founded by James VI., 1581.</p> <p>William Clowes, surgeon to St. Bartholomew's, published his work on ' <i>Syphilis</i>,' 15</p> <p>Dr. M. Powis David wrote ' <i>De senum affectibus</i>,' 1588, Venice. Andreas Baccio, ph</p> <p>Paré died, 1590. Pineau, of Paris, suggested symphysectomy in difficult labour.</p> <p>Sir Simon Baskerville took his degree, physician to James I. and Charles.</p> <p>Dr. Goulston born, 1596 ; died, 1632 (endowed the Goulston Lecture).</p> <p>George Baker, surgeon to Elizabeth, was Master of the Company of Surgeons, 1597 ;</p>
1599	

## MEDICINE.

1599).	Contemporary Events.
<p>personal health, &amp;c.</p> <p>successfully performed by a Swiss sow-gelder. Government, 1512 (at Nuremberg). Cæsarian</p> <p>specially as to which arm should be preferred.</p> <p>ary VIII.</p> <p>[medicine in English. practised at Winchester; the first to write on</p>	<p>Charles V. born.</p> <p>Columbus died, 1506.</p> <p>Henry VIII., King, 1509.</p> <p>Battle of Pavia, 1525.</p> <p>Luther died, 1546. Edward VI., 1547.</p>
<p>Bartholomew's Close.</p> <p>[Anatomy, 1548. ital, 1554, published, in English, a treatise on rote of syphilis as "Chamaleontiasis" (1565). te 'The Government of Health' and 'Regimen memory. [against the Pleurisy,' 1558 &amp; 1562. ; physician to Queen Elizabeth; wrote on eye as Gibson, physician and historian, died, 1562.</p> <p>of the insane. R. Franco improved lithotomy, my, &amp;c., and introduced turning in midwifery. advocate of mercury. to Sextus V., flourished in Rome.</p> <p>lated Paré, and wrote on mercury.</p>	<p>Vicary, first med. off. to St. Bar- tholomew's; with Charles V. Mary, 1553. [in Africa, 1551. Elizabeth, 1553. Abdication of Charles V., 1555.</p> <p>Tobacco mentioned by Harrison, 1573. Croup described by Ballonius, 1576.</p> <p>The Armada, 1588. Henri IV., 1589.</p> <p>Descartes born, 1596.</p>



# A CHRONOLOGY

Dates.	The SEVENTEENTH CENTURY (from 1
<p>1600</p> <p>1650</p> <p>1699</p>	<p>Guy Patin born, 1601. Harvey took his M.D. degree at Padua, and subsequently at Fabricius died, 1603, at Venice. Gilbert died, 1603; he was physician to Elizabeth, Sir Thomas Brown born, 1605.</p> <p>George Bate born, 1608, physician to Charles I., and afterwards to Cromwell (said to</p> <p>Harvey appointed to give lectures at College of Physicians, 1615.</p> <p>Aldrovandus died, at great age, 1615 (Bologna). Jaques de Marque, <i>æt.</i> 46, flourishes</p> <p>The first London Pharmacopœia published, Dr. H. Alkins being President of the Lon</p> <p>Dr. Bathurst born, 1620, poet, physician, and divine.</p> <p>Richard Bannister, a successful operator for cataract, was an old man (1621);</p> <p>Sydenham born, 1624. Hildanus died, 1624.</p> <p>Bacon died, 1626.</p> <p>Harvey published his treatise on 'The Circulation of the Blood' in 1626. He had r</p> <p>Francis Glisson took his degree at Oxford, 1627. Gretorex, the "Irish Stroker," bo</p> <p>Bark first used by the Jesuits.</p> <p>Peter Barwick, <i>æt.</i> 24, took his degree at Cambridge. He was physician to Charles</p> <p>Dr. John Bainbridge died, 1643, a distinguished physician and astronomer (Oxford).</p> <p>Van Helmont died, 1644.</p> <p>'Religio Medici' published.</p> <p>Bidloo born, 1649, Leyden, poet, physician to William III.</p> <p>Radcliffe born.</p> <p>Glisson published 'Anatomia Hepatis,' 1654; died, 1677; 'Treatise on Rickets,' 16</p> <p>Sydenham began private practice, 1656. Helvetius born, 1656.</p> <p>Highmore published his 'Anatomical Disquisition,' 1657.</p> <p>Harvey died, 1658.</p> <p>John Betts practised in London, 1660. He was physician to Charles II., and made</p> <p>Baglivi born, 1668, practised in Rome and died there, <i>æt.</i> 38. Boerhaave born, 166</p> <p>George Cheyne born, 1671; died, <i>æt.</i> 72 (the English malady).</p> <p>Dr. John Archer published, 'Every Man his own Physician,' 1673. Mead born, 167</p> <p>John Freind born, 1675; died, 1728.</p> <p>William Briggs published his 'Ophthalmographia,' 1677, born in Norwich, physic</p> <p>Wiseman published he was an early advocate of primary ampu</p> <p>Willenius, botanist, born at Darmstadt, 1681. Sir Thomas Browne died, 1682.</p> <p>Astruc born, 1684. Edward Browne (son of Sir Thomas), physician to Charles II. a</p> <p>Diembrook published his 'Miscellany,' 1685.</p> <p>Cheselden born, 1688.</p> <p>Sydenham died, 1689.</p> <p>Berri, chemist and quack, died, <i>æt.</i> 79, 1695, in Castle of St. Angelo.</p> <p>Sir Samuel Garth took his M.D. degree, and settled in London. Monro, primus, bo</p>

## OF MEDICINE.

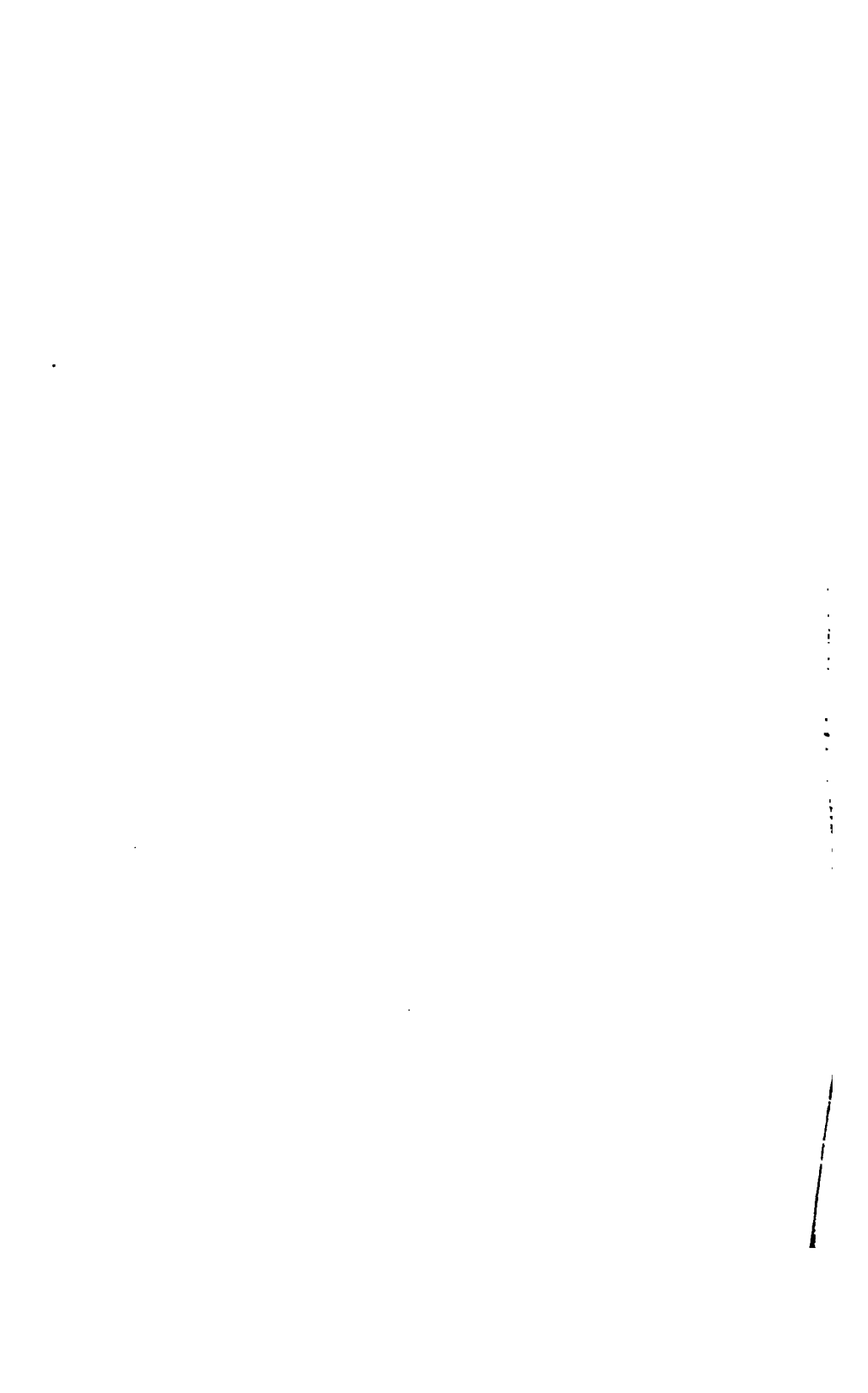
1599 to 1699).	Contemporary Events.
<p>at Cambridge, 1602.  h, who had died in same year, and left him a legacy.  [Dr. Ent born, 1604, a friend of Harvey.  to have hastened the death of the latter).</p> <p>hed in Paris. Casserius died, 1616 (Padua).  ondon College of Physicians.</p> <p>; lived at Stamford, but visited London regularly to  [operate. Father Paul died, 1622.</p> <p>. made the discovery some years before.  orn, 1628. Grew and Ray were both born in 1628.</p> <p>es II., and wrote a defence of Harvey's discovery.  ). Bellini born, 1643, Florence. Bonet (Geneva) took  [his degree, æt. 23; died, 1689.</p>	<p>Shakespeare, æt. 36. Rubens, 23.</p> <p>James I., 1603.  Gunpowder plot, 1605.  Shakespeare died, 1606.  Potatoes introduced.  Rayleigh executed.  Assassination of Henri IV.</p> <p>Charles I., 1625.</p> <p>Gustavus Adolphus killed at  Lutzen, 1632.</p> <p>The Civil War.  [captain in army of parliament.  Newton born, 1642. Sydenham,  Louis XIV., 1643.  The Commonwealth.</p> <p>Descartes died, 1650.</p>
<p>.650.</p> <p>le autopsy on "Old Parr."</p> <p>68, Leyden; died, 1738.</p> <p>573. Petit born, 1674.</p> <p>rian to St. Thomas' Hospital, and a friend of Newton;  putation. [died, 1704.</p> <p>and St. Bartholomew's Hospital.</p> <p>born, 1697.</p>	<p>Restoration of Charles II., 1660.  Coffee introduced.  The Great Plague in London, 1665.  The Great Fire in London, 1666.  Tea came into use, 1667.</p> <p>1687, College of Physicians or-  dered its members to give  advice gratis to poor within  7 miles of London, and fitted  up laboratory for gratuitous  dispensing of medicine. In  reference to this, Gart<sup>h</sup>  his poem, 'The Di</p>

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Dates.	The EIGHTEENTH CENTURY (from 1699)
1700	<p>Dr. Battie born, 1704, a wit, an early reformer in the management of madhouses, phys.  Dr. Barwick died, æt. 86, blind, and suffering from stone, 1705. Baglivi died, 1706.  Linnæus born, 1707. Haller born, 1708, Gottingen.  Dubourg born, 1709, at Mayence, practised in Paris; a friend of Franklin. Cullen bo  John Fothergill born, 1712. Berton born, 1712; died, 1781, Paris; a very distinguisht  Radeliffe died, 1714.  Cleghorn born, 1716, the friend of Fothergill.  Heister published his work on 'Surgery,' 1717, Nuremberg.  William Hunter born, 1718.  Mark Akenside born, 1721.  Richard Brocklesby born, 1722 (a Quaker), a distinguished London physician; he att  Guy's Hospital founded, 1724.  Toussaint Bordenave born, 1728, Paris, Director of Academy of Surgery. Peter Col  Sir Richard Blackmore died, 1729, "who sings so loudly and who sings so lo  Dr. John Armstrong took his degree, 1732 ('Art of Preserving Health,' 1744).  St. George's Hospital founded, 1733.  Dr. Arbuthnot died, 1735 (the friend of Pope and Swift), physician to Queen Anne.  Boerhaave died, 1738.  Hewson born, 1739, Hexham; died, 1774. Cullen took his M.D., 1740. London Ho  Lettsom born, 1744.  Middlesex Hospital founded, 1745.  Bucquet born, Paris, 1746, physician and chemist; died, 1780.  Gæthe born, 1748. Jenner born, 1749.  Petit died.</p>
1750	<p>Cheselden died, 1752 (London).  Samuel Sharp (of Guy's) wrote his Critical Enquiry into the present state of Surgery  Willan born, 1757.  Charles Darwin (son of Erasmus) born, 1758; died, 1778.</p> <p>Abernethy born, 1764.  Astruc died, 1766 (<i>Libri sex de Morbis Veneriis</i>).  Astley Cooper born, 1768.  Akenside died (of fever), 1770.  Dr. John Brown (Brunonianism), æt. 40, President of Medical Society of Edinburgh</p> <p>Haller died, 1777, æt. 70.  Dr. Armstrong died, 1779.  Dr. Fothergill died, 1780.  Dr. W. Hunter died, 1783. Brodie born, 1783. Lawrence born, 1783.</p> <p>Bouvard, æt. 70, died, 1787, an excellent and most successful Paris physician.  Bright born, 1789.  Cullen died, 1790.  Addison born, 1793.  Hunter died, 1793.  Desault died, 1795.  James Syme born, 1799—1870.</p>

## MEDICINE.

o 1799).	Contemporary Events.
<p>n to St. Luke's.</p> <p>1710. anatomist and practitioner.</p> <p>[Burke; uncle of Dr. Young. d Wilkes after his duel; friend of Johnson and [1728; Freind died. n, botanist, elected F.R.S. John Hunter born, Douglas published his 'Description of the [Peritoneum,' 1730.</p> <p>rgman, Prof. Chem., Upsal, born, 1735, a friend [of Linnæus; died, 1784.</p> <p>l founded, 1740.</p>	<p>Voltaire born. Anne, 1702.</p> <p>Peter the Great's reforms in Russia, 1709—1725. George I., 1714. Louis XIV. died, 1715. Brocklesby was with the German army during the Seven Years' War. Mead assisted at trials of inocu- lation, 1721. The royal princesses inoculated, 1722. John Howard born, 1726. Newton died, 1727. George II., 1727.</p>
<p>4). Mead died, æt. 80.</p> <p>pure like Sancho Panza).</p>	<p>The Earthquake of Lisbon, 1755.</p> <p>George III., 1760.</p> <p>Louis XV. died of small-pox, 1774.</p> <p>American Independence, 1783. Dr. Lettsom introduced mangel- wurzel. John Howard died, 1790. The Reign of Terror, 1792—1794.</p>





# A CHRONOL

Dates.	The NINETEENTH CENTURY (1
1800	<p>Vaccination introduced.  Trousseau born, 1801.  Owen born, 1804. Moorfields Ophthalmic Hospital founded.  Duchenne born, 1806. Royal Jennerian Hospital founded, 1806.</p> <p>Darwin born, 1809.  Claude Bernard born, 1813— 1878.  Paget born, 1814.  Simon born, 1816.  The stethoscope introduced. Semmelweis, " the father of antiseptic midwifer  Quinine discovered, 1820.  Virchow born, 1821.  Pasteur born, 1822. Jenner died, 1823.  Huxley born, 1825. Charcot born, 1825.  Lister born, 1827.</p> <p>Iodide of potassium first used.  Dupuytren died, 1835.  The Orthopædic Hospital founded, 1838.</p> <p>Astley Cooper died, 1841.  Koch born, 1843.  The ophthalmoscope.  Anæsthetics introduced. Morton used ether, 1846. Simpson, chloroform, 18  The clinical thermometer.</p>
1850	<p>Bright died, 1858.  Antiseptic surgery.  Ovariectomy perfected.  Lithotripsy perfected.  Addison died, 1860.  Brodie died, 1862.</p> <p>Discovery of Bacillus of Tubercle by Koch.  Watson died, 1882.</p> <p>Owen died, 1892.</p>
1900	

## 7 *MEDICINE.*

to 1900).

### Contemporary Events.

8.

George III.

Battle of Leipsic, 1813.

Waterloo, 1815.

George IV., 1820.

William IV., 1830.

Victoria, 1837.

Darwin died.

Victorian Jubilee (1887).

Tennyson died, 1892.





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